

HRSA Electronic Handbooks (EHB)

FY 2017 New Access Points (NAP)

HRSA-17-009

User Guide for Applicants

Last updated on March 11, 2016



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This user guide describes the steps you need to follow in order to submit a Fiscal Year (FY) 2017 New Access Points (NAP) application to the Health Resources and Services Administration (HRSA). This user guide does not replace the Funding Opportunity Announcement, which details the NAP program requirements and the instructions for application development. See the NAP technical assistance webpage at <http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP> for additional resources.

1. Starting the FY 2017 NAP Application

Complete and submit the FY 2017 NAP application by following a two-step process:

1. Locate the funding opportunity in Grants.gov, download the application package, and submit the required application forms in Grants.gov. To find the application package, search by the announcement number HRSA-17-009 in Grants.gov.
2. You must validate, complete, and submit this application in the HRSA Electronic Handbooks (EHB). To validate the Grants.gov application, log into EHB and click on the **Grant Applications** link under the Tasks tab (**Figure 1, 1**) and then click on the *Grants.Gov Application Pending Validation: Validate* link (**Figure 1, 2**). You will need your Grants.gov and EHB tracking numbers (emailed after successful Grants.gov submission) (**Figure 2**).

Figure 1: Grant Applications Link



Figure 2: Validating your Grant.gov Application

Grants.Gov Application - Validate

Note(s):
In order to ensure that the correct persons are given permissions to work on this Grants.gov application, you must enter the following validation information from the submitted Grants.gov application

Fields with * are required

Announcement Information

* Announcement Number
(From submitted Grants.gov application) (e.g. HRSA-04-061 or 04-061)

Grants.gov Application Information

* Grants.gov Tracking Number
(From submitted Grants.gov application) (e.g. GRANT00059900)

EHBs Application Information

* EHBs Application Tracking Number
(From email notification) (e.g. 00025328)

IMPORTANT NOTE: Refer to the HRSA SF-424 Two Tier Application Guide (<http://www.hrsa.gov/grants/apply/applicationguide/sf424programspecificappguide.pdf>) for details related to submitting the application in Grants.gov and validating it in EHB.

Once the application is validated in EHB, you can access it in your pending tasks. To access the application in EHB, follow the steps below:

1. After logging into EHB, click the Tasks tab on the EHB **Home** page to navigate to the **Pending Tasks – List** page.

IMPORTANT NOTE: If you do not have a username, you must register in EHB. Do not create duplicate accounts. If you experience log in issues or forget your password, contact the Bureau of Primary Health Care (BPHC) Helpline at <http://www.hrsa.gov/about/contact/bphc.aspx> or (877) 974-2742.

2. Locate the NAP application using the EHB application tracking number and click the **Start** link to begin working on the application in EHB.
 - The system opens the **Application - Status Overview** page of the application (**Figure 3**).

Figure 3: Application - Status Overview Page

List of forms that are part of the application package		
Section	Status	Options
Basic Information 1		
SF-424	Not Started	
Part 1	Not Started	Update
Part 2	Not Started	Update
Project/Performance Site Location(s)	Not Started	Update
Project Narrative	Not Started	Update
Budget Information 2		
Section A-C	Not Started	Update
Section D-F	Not Started	Update
Budget Narrative	Not Started	Update
Other Information 3		
Assurances	Not Started	Update
Disclosure of Lobbying Activities	Not Started	Update
Appendices	Not Started	Update
Program Specific Information		
Program Specific Information	Not Complete	Update

The application consists of a standard section and a program specific section. You must complete the forms displayed in both of these sections to submit your application to HRSA. Click Update to access each section.

2. Completing the Standard SF-424 Section of the Application

The standard SF-424 section of the application consists of the following main sections:

- [Basic Information](#) (Figure 3, 1)
- [Budget Information](#) (Figure 3, 2)
- [Other Information](#) (Figure 3, 3)

2.1 Completing the Basic Information Section

The Basic Information has been imported from Grants.gov and has undergone a data validation check. You may edit this information if necessary. Only the fields marked with a star * are required for completion. This section consists of the following forms:

- The **SF-424 Part 1** form displays basic information about the application and the applicant organization.
- The **SF-424 Part 2** form displays information about the proposed project, including: the project title, project period, cities, counties, and Congressional districts affected by the project.

- The Project Abstract has been imported from Grants.gov and placed under the Project Description section (**Figure 4, 1**). You may update the abstract as necessary, by clicking the arrow next to the **Update Description** link, and selecting Delete to remove the Grants.gov version (**Figure 4, 2**). Then upload an updated abstract by clicking Attach File.

Figure 4: Project Description on SF-424 Part 2

The screenshot displays the 'SF-424 - Part 2' form. At the top, there are tabs for 'SF-424 - Part 1' and 'SF-424 - Part 2'. Below the tabs, a section titled 'Fields with * are required' contains a dropdown menu for 'Areas Affected by Project (Cities, Counties, States, etc.) (Minimum 0) (Maximum 1)' with an 'Attach File' button. Below this is a section for 'Descriptive Title of Applicant's Project' with the text 'Health Center Cluster'. The main section is 'Project Description (Minimum 1) (Maximum 1)', which contains a table with columns: Document Name, Size, Date Attached, Description, and Options. The table has one row: 'Project Abstract.docx', '11 kB', '10/10/2018', 'Project Abstract from Grant.gov'. A red box labeled '1' highlights the 'Project Description (Minimum 1) (Maximum 1)' header. In the 'Options' column, there is an 'Action' dropdown menu with 'Update Description' and 'Delete' options. A red box labeled '2' highlights these two options.

- In the Congressional Districts fields, select the congressional district where the applicant organization is located. Also select the congressional district where the new access point is located. If you need to include additional congressional districts, you may upload an attachment with the relevant information by clicking the Attach File button on the 'Additional Program/Project Congressional Districts' line.
- For the Proposed Project Period, enter 01/01/2017 to 12/31/2018.
- The Estimated Funding section will update automatically when edits are made to the Budget Information section.
- Refer to the HRSA SF-424 Two Tier Application Guide (<http://www.hrsa.gov/grants/apply/applicationguide/sf424programspecificappguide.pdf>) for details related to the Executive Order 12372 process.
- The **Project/Performance Site Location(s)** form, provided in Grants.gov, displays the site locations where you propose to provide services through the proposed NAP project. You may update the information provided from Grants.gov.
- In the **Project Narrative** form, attach the Project Narrative by clicking the Attach File button (**Figure 5, 1**).

Figure 5: Project Narrative

The screenshot shows a web form titled "Project Narrative". At the top right, it displays "Due Date: 8/7/2016 5:45:00 PM (Due in: 88 days) | Section Status: Not Complete". Below the title is a "Resources" section with a "View" button and links for "Application", "Action History", "Funding Opportunity Announcement", "FOA Guidance", and "Application User Guide". A note states "Fields with * are required". The main section is "Project Narrative (Minimum 1) (Maximum 2)", which is currently empty and shows "No documents attached". An "Attach File" button is visible on the right. At the bottom, there are buttons for "Go to Previous Page", "Save", and "Save and Continue".

2.2 Completing the SF-424A Budget Information

For this section, you must complete the **Budget Information** [Section A-C](#) and [D-F](#) forms and provide a [Budget Justification Narrative](#).

2.2.1 Budget Information – Section A-C
























The **Budget Information – Section A-C** form consists of the following three sections:

- Section A – Budget Summary
- Section B – Budget Categories
- Section C – Non-Federal Resources

To complete this form, follow the steps below:

1. Click the [Update](#) link for Section A-C on the **Application - Status Overview** page ([Figure 6](#)).

Figure 6: Budget Information Section A-C Update Link

List of forms that are part of the application package		
Section	Status	Options
Basic Information		
SF-424	 Not Started	
Part 1	 Not Started	 Update
Part 2	 Not Started	 Update
Project/Performance Site Location(s)	 Not Started	 Update
Project Narrative	 Not Started	 Update
Budget Information		
Section A-C	 Not Started	 Update
Section D-F	 Not Started	 Update
Budget Narrative	 Not Started	 Update
Other Information		
Assurances	 Not Started	 Update
Disclosure of Lobbying Activities	 Not Started	 Update
Appendices	 Not Started	 Update
Program Specific Information		
Program Specific Information	 Not Complete	 Update

- The system navigates to the **Budget Information – Section A-C** form ([Figure 7](#)).

Figure 7: Budget Information – Section A-C Page

Budget Information - Section A-C

Due Date: 07/06/2016 05:00:00 PM (Due in: 00 days) | Section Status: Not Complete

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | Application User Guide

Fields with * are required

*** Section A - Budget Summary** Update

Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		
		Federal	Non-Federal	Federal	Non-Federal	Total
Community Health Centers	83.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Care for the Homeless	93.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Migrant Health Centers	93.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Public Housing	83.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Update Sub Program 1	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

*** Section B - Budget Categories** Update

Object Class Categories	Grant Program Function or Activity		Total
	Federal	Non-Federal	
Personnel	\$0.00	\$0.00	\$0.00
Fringe Benefits	\$0.00	\$0.00	\$0.00
Travel	\$0.00	\$0.00	\$0.00
Equipment	\$0.00	\$0.00	\$0.00
Supplies	\$0.00	\$0.00	\$0.00
Contractual	\$0.00	\$0.00	\$0.00
Construction	\$0.00	\$0.00	\$0.00
Other	\$0.00	\$0.00	\$0.00
Total Direct Charges	\$0.00	\$0.00	\$0.00
Indirect Charges	\$0.00	\$0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00

*** Section C - Non Federal Resources** Update

Grant Program Function or Activity	Applicant	State	Local	Other	Program Income	Total
Community Health Centers	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Care for the Homeless	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Migrant Health Centers	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Public Housing	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

[Go to Previous Page](#) Save Save and Continue

- Review the pre-populated sub programs (i.e., funding streams). If the pre-populated information does not reflect the funding streams to be proposed in the NAP project, under **Section A – Budget Summary**, click the Update Sub Program button (Figure 7, 1). If you do not need to modify the sub program selections, move to step 3.
 - The **Sub Programs – Update** page opens (Figure 8).
 - Select or unselect the sub programs. Only select the programs for which you are requesting funding.
 - Click the Save and Continue button.
 - The **Budget Information – Section A-C** page re-opens showing the selected sub program(s) under the Section A – Budget Summary (Figure 9, 1).

Figure 8: Sub Programs – Update Page

Sub Programs - Update

Due Date: 8/30/2016 11:59:59 PM (Due in: 0 days) | Section Status: Not Complete

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | Application User Guide

Sub Programs

<input type="checkbox"/>	Sub-Program	CFDA
<input type="checkbox"/>	Community Health Centers	93.224
<input checked="" type="checkbox"/>	Health Care for the Homeless	93.224
<input type="checkbox"/>	Migrant Health Centers	93.224
<input type="checkbox"/>	Public Housing	93.224

Cancel Save and Continue

Figure 9: Section A – Budget Summary Showing Addition of Sub Program

Section A - Budget Summary

Update

Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		Total
		Federal	Non-Federal	Federal	Non-Federal	
Health Care for the Homeless	93.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Migrant Health Centers	93.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Update Sub Program

- To enter or update the budget information for each sub program, click the Update button displayed in the top right corner of the Section A – Budget Summary header (Figure 9, 2).
 - The **Section A – Update** page opens.

Figure 10: Section A – Update Page

Section A - Update

Due Date: 8/30/2016 11:59:59 PM (Due in: 0 days) | Section Status: Not Complete

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | Application User Guide

Fields with * are required

Section A - Budget Summary

Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		Total
		Federal	Non-Federal	Federal	Non-Federal	
Health Care for the Homeless	93.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Migrant Health Centers	93.224	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Cancel Save and Continue

- Under the **New or Revised Budget** section, in the Federal column, enter the amount of federal funds requested for the first 12-month period of the NAP project for each requested sub program (CHC, MHC, HCH, and/or PHPC) (Figure 10, 1). In the Non-Federal column, enter the non-federal funds in the budget for the first 12-month period for each requested sub program (Figure 10, 2). Do not enter amounts in the Estimated Unobligated Funds columns.

IMPORTANT NOTE: The federal amount refers only to the NAP funding request, not all federal grant funding that an applicant receives. The total federal amount cannot exceed \$650,000.

5. Click the Save and Continue button.

- The **Budget Information – Section A-C** page re-opens displaying the updated New or Revised Budget under Section A – Budget Summary ([Figure 11](#)).

Figure 11: Section A – Budget Summary Page after Update

Section A - Budget Summary Update						
Grant Program Function or Activity	CFDA Number	Estimated Unobligated Funds		New or Revised Budget		
		Federal	Non-Federal	Federal	Non-Federal	Total
Health Care for the Homeless	93.224	\$0.00	\$0.00	\$30,000.00	\$0.00	\$30,000.00
Migrant Health Centers	93.224	\$0.00	\$0.00	\$20,000.00	\$0.00	\$20,000.00
Update Sub Program	Total	\$0.00	\$0.00	\$50,000.00	\$0.00	\$50,000.00

6. In Section B – Budget Categories, provide the federal and non-federal funding distribution across object class categories for the first 12-month period. Click the Update button provided at the top right corner of the Section B header ([Figure 12](#)).

Figure 12: Section B – Budget Categories

Section B - Budget Categories Update			
Object Class Categories	Grant Program Function or Activity		Total
	Federal	Non-Federal	
Personnel	\$0.00	\$0.00	\$0.00
Fringe Benefits	\$0.00	\$0.00	\$0.00
Travel	\$0.00	\$0.00	\$0.00
Equipment	\$0.00	\$0.00	\$0.00
Supplies	\$0.00	\$0.00	\$0.00
Contractual	\$0.00	\$0.00	\$0.00
Construction	\$0.00	\$0.00	\$0.00
Other	\$0.00	\$0.00	\$0.00
Total Direct Charges	\$0.00	\$0.00	\$0.00
Indirect Charges	\$0.00	\$0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00

- The system navigates to the **Section B – Update** page ([Figure 13](#)).

7. Enter the federal dollar amount for each applicable object class category under the Federal column ([Figure 13, 1](#)).

In Year 1 only, up to \$150,000 may be requested for equipment (enter on the Equipment row) and/or minor alterations/renovations (enter on the Construction row). The one-time funding information entered in [Form 1B: BPHC Funding Request Summary](#) must be consistent with the request here in Section B of the SF-424A Budget Information form.

8. Similarly, enter the non-federal dollar amount for each applicable object class category under the Non-Federal column ([Figure 13, 2](#)). Applicants must present the total budget for the NAP project,

which includes all non-grant funds (i.e., Non-Federal funding), including both program income and all other non-grant funding sources that support the NAP scope of project. See the Policy Information Notice 2013-01 at <http://bphc.hrsa.gov/programrequirements/pdf/pin201301.pdf> for additional information on health center budgeting.

Figure 13: Section B – Update Page

Section B - Update

Note(s):
 Total federal amount in Section B must be equal to the total new or revised budget, federal amount specified in budget summary (section A) \$50,000.00.
 Total non-federal amount in Section B must be equal to the total new or revised budget, non-federal amount specified in budget summary (section A) \$0.00.

▶ **SHANE LAFINE COMMUNITY HEALTH CENTER** Due Date: 8/30/2016 11:59:00 PM (Due in: 30 days) | Section Status: Not Complete

▼ **Resources** [View](#)
 Application | Action History | Funding Opportunity Announcement | FOA Guidance

Fields with * are required

*** Section B - Budget Categories**

Object Class Categories	Grant Program Function or Activity		Total
	Federal	Non-Federal	
Personnel	\$ 0.00	\$ 0.00	\$0.00
Fringe Benefits	\$ 0.00	\$ 0.00	\$0.00
Travel	\$ 0.00	\$ 0.00	\$0.00
Equipment	\$ 0.00	\$ 0.00	\$0.00
Supplies	\$ 0.00	\$ 0.00	\$0.00
Contractual	\$ 0.00	\$ 0.00	\$0.00
Construction	\$ 0.00	\$ 0.00	\$0.00
Other	\$ 0.00	\$ 0.00	\$0.00
Indirect Charges	\$ 0.00	\$ 0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00
Total Budget specified in Budget Summary (Section A)	\$50,000.00	\$0.00	\$50,000.00

Cancel 3 **Save and Continue**

IMPORTANT NOTES:

- The total federal amount in Section B – Budget Categories must be equal to the total new or revised federal budget amount specified in Section A – Budget Summary of the Budget Information – Section A-C page (no greater than \$650,000).
- The total non-federal amount in Section B – Budget Categories must be equal to the total new or revised non-federal budget amount specified in Section A – Budget Summary of the Budget Information – Section A-C page.

9. Click the Save and Continue button (**Figure 13, 3**) to navigate to the **Budget Information – Section A-C** page (**Figure 7**).
10. In Section C – Non Federal Resources, distribute the non-federal budget amount specified in Section A – Budget Summary across the applicable non-federal resources. Click the Update button in the top right corner of Section C header to do so (**Figure 14, 1**). Include other non-NAP federal funds in

the “other” category, if applicable. Program Income should be consistent with the Total Program Income (patient service revenue) presented in Form 3: Income Analysis.

Figure 14: Section C - Non Federal Resources

Grant Program Function or Activity	Applicant	State	Local	Other	Program Income	Total
Health Care for the Homeless	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Migrant Health Centers	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

IMPORTANT NOTE: The total non-federal amount in Section C – Non Federal Resources must be equal to the total new or revised non-federal budget amount specified in Section A – Budget Summary of the **Budget Information – Section A-C** form.

11. Click the Save and Continue button to proceed to the next form (Figure 14, 2).

2.2.2 Budget Information – Section D-F

The **Budget Information – Section D-F** page consists of the following three sections:

- Section D – Forecasted Cash Needs
- Section E – Federal Funds Needed for Balance of the Project
- Section F – Other Budget Information

Figure 15: Budget Information – Section D-F

Budget Information - Section D-F

Due Date: 10/25/2018 11:00:00 PM (Due in: 28 days) | Section Status: Not Complete

Section D - Forecasted Cash Needs

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Federal	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Non-Federal	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Section E - Federal Funds Needed for Balance of the Project

Grant Program	Future Funding Periods (Years)			
	First	Second	Third	Fourth
Health Care for the Homeless	\$0.00	\$0.00	\$0.00	\$0.00
Migrant Health Centers	\$0.00	\$0.00	\$0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00	\$0.00

Section F - Other Budget Information

Direct Charges: No information added.

Indirect Charges: No information added.

Remarks: No information added.

To complete this form, follow the steps below:

1. Section D – Forecasted Cash Needs is optional and may be left blank. However, you may enter the amount of cash needed by quarter during the first year for both the federal and non-federal request. Click the Update button in the top right corner of Section D to do so ([Figure 15, 1](#)).
2. In Section E – Federal Funds Needed for Balance of the Project, click the Update button in the top right corner of Section E to request NAP funding for Budget Year 2 ([Figure 15, 2](#)). Enter the NAP funding requested for Year 2 in the “First” column under Future Funding Periods (Years), broken down for each proposed type of Health Center Program funding (CHC, MHC, HCH, and/or PHPC). ([Figure 15, 5](#)). The maximum amount that may be requested for Year 2 cannot exceed \$650,000. The Second, Third, and Fourth year columns must remain \$0.
3. In Section F – Other Budget Information, you may provide information regarding direct and indirect charges (if any). You can also document any relevant comments or remarks in this section. Click the Update button provided in the top right corner of Section F to do so ([Figure 15, 3](#)).
4. Finally, click the Save and Continue button on the **Budget Information – Section D-F** to proceed to the next form ([Figure 15, 4](#)).

2.2.3 Budget Justification Narrative

Attach a budget justification narrative by clicking the Attach File button ([Figure 16, 1](#)). Once completed, click the Save and Continue button to proceed to the next form.

IMPORTANT NOTE: If using Excel or other spreadsheet documents, do not use multiple pages (sheets). Make sure that the information that needs to be viewed is set in the “Print Area” of the document if the Budget Justification Narrative is presented as a spreadsheet.

Figure 16: Budget Justification Narrative

2.3 Completing the Other Information section

The Other Information section consists of the Assurances, Disclosure of Lobbying Activities, and Appendices forms. You must complete all three forms in order to complete this section.

2.3.1 Completing the Assurances Form

The **Assurances** form verifies that you are aware of and agree to comply with all federal requirements should NAP funds be awarded. To complete this form, you must select ‘Agree’ on the certification question at the bottom of the form ([Figure 17, 1](#)). The name of the Authorizing Official will prepopulate when the

application is submitted. Click on the Save and Continue button to proceed to the **Disclosure of Lobbying Activities** form.

Figure 17: Assurances

Assurances

Due Date: 07/15/2015 10:40:32 AM (Due in: 37 days) | Section Status: Not Complete

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | Application User Guide

SF-424B: Assurances, Non-Construction

As the duly authorized representative of the applicant, I certify that the applicant:

- Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.
- Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award, and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
- Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
- Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
- Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
- Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
- Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
- Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7326) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
- Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.
- Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
- Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
- Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
- Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
- Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
- Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
- Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4901 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.
- Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. 45 CFR 75, "Audits of States, Local Governments, and Non-Profit Organizations."
- Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.
- Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

Certification

Name of the authorized certifying official

Title

Applicant organization

I certify that I have read and agree to comply with the requirements of form SF-424B upon award of funds.

☐ Agree ☒ Do not agree

Go to Previous Page Save Save and Continue

2.3.2 Completing the Disclosure of Lobbying Activities Form

Answer the question regarding lobbying activities. If yes, complete all sections of the **Disclosure of Lobbying Activities** form. If no, the remainder of the form is optional. Click the Save and Continue button to proceed to the **Appendices** form.

IMPORTANT NOTE: If you certify that you do NOT currently receive more than \$100,000 in federal funds and engage in lobbying activities, you are not required to complete the Disclosure of Lobbying Activities form.

2.3.3 Completing the Appendices Form

To complete the **Appendices** form, upload the following attachments by clicking the associated Attach File buttons:

- Attachment 1: Service Area Map and Table (required)
- Attachment 2: Implementation Plan (required)
- Attachment 3: Applicant Organizational Chart (required)
- Attachment 4: Position Descriptions for Key Management Staff (required)
- Attachment 5: Biographical Sketches for Key Management Staff (required)
- Attachment 6: Co-Applicant Agreement (required for public center applicants that have a co-applicant board)
- Attachment 7: Summary of Contracts and Agreements (as applicable)
- Attachment 8: Independent Financial Audit (required)
- Attachment 9: Articles of Incorporation (required for NEW START APPLICANTS)
- Attachment 10: Letters of Support (required)
- Attachment 11: Sliding Fee Discount Schedule(s) (required)
- Attachment 12: Evidence of Nonprofit or Public Center Status (required for NEW START APPLICANTS)
- Attachment 13: Floor Plans (required)
- Attachment 14: Corporate Bylaws (required)
- Attachment 15: Indirect Cost Rate Agreement & Other Relevant Documents (as applicable)

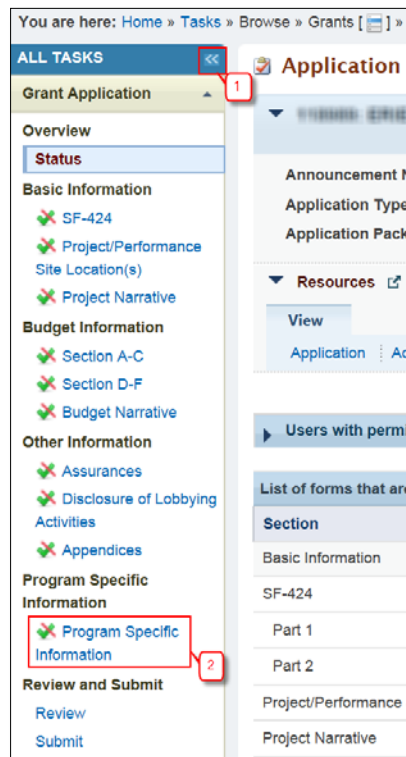
IMPORTANT NOTE: See Section 5.2 of HRSA's SF-424 Two-Tier Application Guide at <http://www.hrsa.gov/grants/apply/applicationguide/sf424programspecificappguide.pdf> for attachment formatting Guidelines.

After completing the **Appendices** form, click the Save and Continue button to proceed to the **Program Specific Information – Status Overview** page.

3. Completing the Program Specific Forms

1. Expand the left navigation menu if not already expanded by clicking the double arrows displayed near the form name at the top of the page (**Figure 18, 1**). Click the **Program Specific Information** link (**Figure 18, 2**) under the Program Specific Information section in the left menu to open the **Status Overview** page for the Program Specific Information forms (**Figure 19**). Click the **Update** link to edit a form (**Figure 19, 1**).

Figure 18: Left Navigation Menu



IMPORTANT NOTE: Your session remains active for 30 minutes after your last activity. Save your work every five minutes to avoid losing data.

Figure 19: Status Overview Page for Program Specific Forms

Status Overview

Due Date: 09/11/2016 (Due In: 0 Days) | **Program Specific Status:** Not Complete

Announcement Number: HRSA-16-028	Announcement Name: Affordable Care Act New Access Point Grants	Application Type: New
Grant Number: Not Available	Target Population: Community Health Centers, Health Care for the Homeless	

Resources [↗](#)

View

NAP FY 2016 User Guide Funding Opportunity Announcement

Program Specific Information Status		
Section	Status	Options
General Information		
Form 1A - General Information Worksheet	✖ Not Started	Update
Form 1C - Documents On File	✖ Not Started	Update
Form 4 - Community Characteristics	✖ Not Started	Update
Budget Information		
Form 1B - Funding Request Summary	✖ Not Started	Update
Form 2 - Staffing Profile	✖ Not Started	
Year 1	✖ Not Started	Update
Year 2	✖ Not Started	Update
Form 3 - Income Analysis	✖ Not Started	Update
Sites and Services		
Form 5A - Services Provided	✖ Not Started	
Required Services	✖ Not Started	Update
Additional Services	✖ Not Started	Update
Form 5B - Service Sites	✖ Not Started	Update
Form 5C - Other Activities/Locations	✖ Not Started	Update
Alteration/Renovation (A/R) Information	✖ Not Started	Update
Other Forms		
Form 6A - Current Board Member Characteristics	✖ Not Started	Update
Form 6B - Request for Waiver of Governance Requirements	✖ Not Started	Update
Form 8 - Health Center Agreements	✖ Not Started	Update
Form 9 - Need for Assistance Worksheet	✖ Not Started	
Section I - Core Barriers	✖ Not Started	Update
Section II - Core Health Indicators	✖ Not Started	Update
Section III - Other Health and Access Indicators	✖ Not Started	Update
Form 10 - Annual Emergency Preparedness Report	✖ Not Started	Update
Form 12 - Organization Contacts	✖ Not Started	Update
Performance Measures		
Clinical Performance Measures	✖ Not Started	Update
Financial Performance Measures	✖ Not Started	Update
Other Information		
Equipment List	✖ Not Started	Update
Summary Page	✖ Not Started	Update

[Return to Complete Status](#)

3.1 Form 1A: General Information Worksheet

Form 1A - General Information Worksheet provides a summary of information related to the applicant, proposed service area, population, and patient and visit projections. This form is comprised of the following sections:

- Applicant Information (Figure 20, 1)
- Proposed Service Area (Figure 20, 2)

Figure 20: Form 1A: General Information Worksheet

Form 1A - General Information Worksheet

Due Date: 10/15/2018 (Due In: 10 Days) | Section Status: Not Started

Resources

Fields with * are required

1. Applicant Information

Applicant Name	[Redacted]
* Fiscal Year End Date	Select Option
Application Type	New
Existing Grantee	No
Grant Number	N/A
* Business Entity	Select Option
* Organization Type (Select all that apply)	<input type="checkbox"/> All <input type="checkbox"/> Faith based <input type="checkbox"/> Hospital <input type="checkbox"/> State government <input type="checkbox"/> City/County/Local Government or Municipality <input type="checkbox"/> University <input type="checkbox"/> Community based organization <input type="checkbox"/> Other
If "Other" please specify:	(maximum 100 characters)

2. Proposed Service Area

Note(s):
Applicants applying for Community Health Center funding must serve at least one MUA or MUP. Provide the IDs for all MUAs and/or MUPs within your service area.

2a. Service Area Designation

* Select MUA/MUP
(Each ID must be a 5 digit integer. Use commas to separate multiple IDs, without spaces)

Find an MUA/MUP

- ☐ Medically Underserved Area (MUA) ID # []
- ☐ Medically Underserved Population (MUP) ID # []
- ☐ Medically Underserved Area Application Pending ID # []
- ☐ Medically Underserved Population Application Pending ID # []

2b. Service Area Type

* Choose Service Area Type

☐ Urban
☐ Rural
☐ Sparsely Populated - Specify population density by providing the number of people per square mile: [] (Provide a value ranging from 0.01 to 7)

2c. Patients and Visits

Patients and Visits by Service Type

Service Type	UDS / Baseline Value		Projected by December 31, 2018 (January 1 - December 31 2018)	
	Patients	Visits	Patients	Visits
* Total Medical Services	N/A	N/A	[]	[]
* Total Dental Services	N/A	N/A	[]	[]
Behavioral Health Services				
* Total Mental Health Services	N/A	N/A	[]	[]
* Total Substance Abuse Services	N/A	N/A	[]	[]
* Total Enabling Services	N/A	N/A	[]	[]

Unduplicated Patients and Visits by Population Type

Population Type	UDS / Baseline Value		Projected by December 31, 2018 (January 1 - December 31 2018)	
	Patients	Visits	Patients	Visits
* Total	N/A	N/A	[]	[]
* General Underserved Community (Include all patients/visits not reported in the rows below)	N/A	N/A	[]	[]
* Migratory and Seasonal Agricultural Workers	N/A	N/A	[]	[]
* Public Housing Residents	N/A	N/A	[]	[]
* People Experiencing Homelessness	N/A	N/A	[]	[]

[Go to Previous Page](#)
[Save](#)
[Save and Continue](#)

3.1.1 Completing the Applicant Information Section

The **Applicant Information** section is pre-populated with application and grant-related information, as applicable. Complete this section by providing information in the following required fields (**Figure 21**):

1. In the 'Fiscal Year End Date' field, select month and day of the applicant organization's fiscal year end date (e.g., June 30) to inform HRSA of the expected audit submission timeline in the Federal Audit Clearinghouse (<https://harvester.census.gov/facweb/default.aspx>).
2. Select one category in the 'Business Entity' field. An applicant that is a Tribal or Urban Indian entity and also meets the definition for a public or private entity should select the Tribal or Urban Indian category.
3. Select one or more categories for the 'Organization Type.' If you choose to select 'Other' as one of the Organization Type values (**Figure 21, 1**), you must specify the organization type

Figure 21: Applicant Information Section

The screenshot shows the '1. Applicant Information' section of a web form. It contains several fields: 'Applicant Name' (text input), 'Fiscal Year End Date' (dropdown menu), 'Application Type' (text input, value: New), 'Existing Grantee' (text input, value: No), 'Grant Number' (text input, value: N/A), 'Business Entity' (dropdown menu), and 'Organization Type (Select all that apply)' (checkbox list). The 'Organization Type' list includes: All, Faith based, Hospital, State government, City/County/Local Government or Municipality, University, Community based organization, and Other. The 'Other' option is selected, indicated by a red box with the number '1' next to it. Below the list is a text input field for 'If "Other" please specify:' with a note '(maximum 100 characters)'.

3.1.2 Completing the Proposed Service Area Section

The Proposed Service Area section is further divided into the following sub-sections:

- [2a. Service Area Designation](#)
- [2b. Service Area Type](#)
- [2c. Patients and Visits](#)
 - Patients and Visits by Service Type
 - Unduplicated Patients and Visits by Population Type

3.1.2.1 Service Area Designation

In the **Select MUA/MUP** field (**Figure 22, 1**), select the options that best describe the designated service area you propose to serve. Enter ID number(s) for the MUA and/or MUP in the proposed service area.

IMPORTANT NOTE: If you are applying for Community Health Centers funding, you must provide an ID number for at least one of the line items listed in this field. Otherwise, providing an MUA or MUP ID number is optional.

Figure 22: Service Area Designation

Note(s):
Applicants applying for Community Health Center funding must serve at least one MUA or MUP. Provide the IDs for all MUAs and/or MUPs within your service area.

2a. Service Area Designation

*** Select MUA/MUP**
(Each ID must be a 5 digit integer. Use commas to separate multiple IDs, without spaces)

[Find an MUA/MUP](#)

☐ Medically Underserved Area (MUA) ID #

☐ Medically Underserved Population (MUP) ID #

☐ Medically Underserved Area Application Pending ID #

☐ Medically Underserved Population Application Pending ID #

3.1.2.2 Service Area Type

In the **Service Area Type** section (Figure 23), indicate whether the service area is Urban, Rural, or Sparsely Populated. If Sparsely Populated is selected, specify the population density by providing the number of people per square mile (values must range from 0.01 to 7).

IMPORTANT NOTE: A Sparsely Populated area is defined as a geographical area with seven or fewer people per square mile for the entire service area. For information about rural populations, visit the Office of Rural Health Policy's website (http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html).

Figure 23: Service Area Type Section

2a. Service Area Type

*** Choose Service Area Type**

☐ Urban

☐ Rural

☐ Sparsely Populated - Specify population density by providing the number of people per square mile: (Provide a value ranging from 0.01 to 7)

3.1.2.3 Patients and Visits

To complete this section, follow the steps below:

1. In the **Patients and Visits by Service Type** section, provide the annual number of patients and visits that you project to serve by December 31, 2018 for each applicable service type (Figure 24, 1). Projected by December 31, 2018 values (Figure 24, 1) must include the number of patients that are anticipated to receive services from January 1, 2018 – December 31, 2018 as a direct result of this NAP funding. An individual who receives multiple types of services should be counted once for each service type (e.g., once for medical and once for dental).

Figure 24: Patients and Visits by Service Type

2c. Patients and Visits

Patients and Visits by Service Type

Service Type	UDS / Baseline Value		Projected by December 31, 2018 (January 1 - December 31 2018)	
	Patients	Visits	Patients	Visits
* Total Medical Services	N/A	N/A		
* Total Dental Services	N/A	N/A		
Behavioral Health Services				
* Total Mental Health Services	N/A	N/A		
* Total Substance Abuse Services	N/A	N/A		
* Total Enabling Services	N/A	N/A		

IMPORTANT NOTES:

- The UDS/Baseline Value numbers are not applicable (**Figure 24, 2**).
- The 'Total Medical Services' (**Figure 24, 5**) patient and visit projections (**Figure 24, 1**) must be greater than zero.
- For the 'Total Medical Services' service type (**Figure 24, 5**), the number of Patients must be greater than the number of Patients you provide for each of the 'Total Dental', 'Total Mental Health', 'Total Substance Abuse Services', and 'Total Enabling Services' service types.
- The number of projected visits (**Figure 24, 4**) must be greater than or equal to the number of projected patients (**Figure 24, 3**).
- The Patients and Visits by Service Type section does not have a row for total numbers, since an individual patient may be included in multiple service type categories.

2. In the **Unduplicated Patients and Visits by Population Type** section, provide the total number of patients and visits projected to be served from January 1, 2018 to December 31, 2018 in the **Population Type** 'Total' row (**Figure 25, 1**). The system will validate the total number when you click the Save or Save and Continue button.
3. Provide the number of patients and visits that you project to serve by December 31, 2018 for each listed population type (**Figure 25, 2**). Within each population type, an individual can only be counted once as a patient.

Figure 25: Unduplicated Patients and Visits by Population Type

Unduplicated Patients and Visits by Population Type			
Population Type	UDS / Baseline Value		Projected by December 31, 2018 (January 1 - December 31 2018)
	Patients	Visits	Patients Visits
★ Total	N/A	N/A	<input type="text"/> <input type="text"/>
★ General Underserved Community (Include all patients/visits not reported in the rows below)	N/A	N/A	<input type="text"/> <input type="text"/>
★ Migratory and Seasonal Agricultural Workers	N/A	N/A	<input type="text"/> <input type="text"/>
★ Public Housing Residents	N/A	N/A	<input type="text"/> <input type="text"/>
★ People Experiencing Homelessness	N/A	N/A	<input type="text"/> <input type="text"/>

IMPORTANT NOTES:

- The UDS/Baseline Value numbers are not applicable (**Figure 25, 3**).
- Projected values should include ONLY the number of new patients who are projected to receive services as a result of NAP funding from January 1, 2018 – December 31, 2018. Patient projections from this section will be added to the applicant's overall Patient Target, if funded.

- For the population types corresponding to the sub programs selected in [Section A – Budget Summary](#) form of this application, the number of patients in the Projected by December 31, 2018 column ([Figure 25, 4](#)) must be greater than zero. For the remaining population types, zeroes are acceptable if there are no projected numbers.
- The number of projected visits ([Figure 25, 5](#)) must be greater than or equal to the number of projected patients ([Figure 25, 4](#)).
- The 'General Underserved Community' row must include all patients and visits not captured in the special populations rows.

4. After completing all sections of **Form 1A**, click the Save and Continue button to save your work and proceed to the next form.

3.2 Form 1C: Documents on File

Form 1C - Documents on File displays a list of documents to be maintained by your organization. You are required to provide the date on which each document was last reviewed or revised.

1. To complete **Form 1C**, enter the review/revision dates for each document listed on this form (Figure 26).

Figure 26: Form 1C: Documents on File

Form 1C - Documents on File

Note(s):
Examples of formats that you can use to provide dates on this form are: 01/15/2013, First Monday of every April, bi-monthly (last rev 01/13), etc.

SECTION: TRIBAL/STATE COMMUNITY HEALTH Due Date: 01/15/2018 (Due In: 0 Days) | Section Status: Not Started

Resources

Fields with * are required

Need	Date of Latest Review/Revision (Maximum 100 characters)
* Needs Assessment (Program Requirement 1)	

Management and Finance	Date of Latest Review/Revision (Maximum 100 characters)
* Personnel Policies and/or Procedures, including related Conflict of Interest Provisions (Program Requirements 3, 9, 17, and 19)	
* Data Collection and Confidentiality (Clinical and Financial) Policies and/or Procedures (Program Requirements 8 and 15)	
* Billing and Collection Policies and/or Procedures and Schedule of Fees for Services (Program Requirement 13 and Policy Information Notice 2014-02)	
* Procurement Policies and/or Procedures, including related Conflict of Interest Provisions (Program Requirements 10, 12, and 19)	
* Emergency Preparedness and Management Plan (Policy Information Notice 2007-15)	
* Financial Management/Accounting and Internal Control Policies and/or Procedures (Program Requirements 10 and 12 and Policy Information Notice 2013-01)	
* Contracts and/or Sub-recipient Agreements, as applicable (Program Requirement 10)	

Services	Date of Latest Review/Revision (Maximum 100 characters)
* Sliding Fee Discount Program Policies and/or Procedures (Program Requirement 7 and Policy Information Notice 2014-02)	
* Clinical Protocols/Clinical Care Policies and/or Procedures (Program Requirements 2, 6, and 8)	
* Patient Grievance Policies and/or Procedures (Program Requirements 8 and 17)	
* Quality Improvement and Quality Assurance Plan, including Incident Reporting System and Risk Management Policies and/or Procedures (Program Requirement 8)	
* Malpractice Coverage Plan - e.g., FTCA Coverage for deemed grantees or other malpractice coverage (Program Requirement 8 and FTCA Health Center Policy Manual)	
* Credentialing and Privileging Policies and/or Procedures (Program Requirement 3 and Policy Information Notices 2001-16 and 2002-22)	
* After-Hours Coverage Policies and/or Procedures (Program Requirements 4 and 5)	
* Hospital Admitting Privileges Documentation and/or Arrangements (Program Requirement 6)	

Governance	Date of Latest Review/Revision (Maximum 100 characters)
* Organizational/Board Bylaws, including Conflict of Interest Provisions for Board Members (Program Requirements 17, 18, and 19 and Policy Information Notice 2014-01)	
* Co-Applicant Agreement, if a public agency (Program Requirement 17 and Policy Information Notice 2014-01)	

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

IMPORTANT NOTE: Examples of formats to provide dates on this form are: 01/15/2013, First Monday of every April, bi-monthly (last rev 01/13).

- After completing all sections of **Form 1C**, click the Save and Continue button to save your work and proceed to the next form.

3.3 Form 4: Community Characteristics

Form 4: Community Characteristics reports current service area and target population data for the entire scope of the project (i.e. all NAP sites). “Service Area Number” refers to the entire population in the proposed service area.

Figure 27: Form 4: Community Characteristics

Form 4 - Community Characteristics

Note(s):
The Service Area Percent and Target Population Percent will auto-calculate in EHB and can only be viewed on the read-only version of the form under Review Program Specific Forms in the left side menu.

Due Date: 10/15/2018 (Due In: 18 Days) | Section Status: Not Started

Resources

Fields with * are required

Race 1

	Service Area Number	Target Population Number
* Native Hawaiian		
* Other Pacific Islanders		
* Asian		
* Black/African American		
* American Indian/Alaska Native		
* White		
* More than One Race		
* Unreported/Declined to Report (if applicable)		
Total	0	0

Click the 'Save and Calculate Total' button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form.

Hispanic or Latino Ethnicity 2

	Service Area Number	Target Population Number
* Hispanic or Latino		
* Non-Hispanic or Latino		
* Unreported/Declined to Report (if applicable)		
Total	0	0

Click the 'Save and Calculate Total' button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form.

Income as a Percent of Poverty Level 3

	Service Area Number	Target Population Number
* Below 100%		
* 100-199%		
* 200% and Above		
* Unknown		
Total	0	0

Click the 'Save and Calculate Total' button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form.

Primary Third Party Payment Source 4

	Service Area Number	Target Population Number
* Medicaid		
* Medicare		
* Other Public Insurance		
* Private Insurance		
* None/Uninsured		
Total	0	0

Click the 'Save and Calculate Total' button to calculate and save the total Service Area numbers and Target Population numbers for all sections displayed on this form.

Special Populations 5

	Service Area Number	Target Population Number
* Migratory/Seasonal Agricultural Workers and Families		
* Homeless		
* Residents of Public Housing		
* Lesbian, Gay, Bisexual and Transgender		
* HIV/AIDS-Infected Persons		
* Persons with Behavioral Health/Substance Abuse Needs		
* School Age Children		
* Infants Birth to 2 Years of Age		
* Women Age 25-44		
* Persons Age 65 and Older		
* Other Please specify: Approximately 1/8 page (Max 200 Characters): 200 Characters left.		

9

Go to Previous Page Save Save and Continue

To complete **Form 4**, follow the steps below:

1. Enter the Service Area Number ([Figure 27, 6](#)) and corresponding Target Population Number ([Figure 27, 7](#)) for each of the following categories.
 - a. Race ([Figure 27, 1](#))
 - b. Hispanic or Latino Ethnicity ([Figure 27, 2](#))
 - c. Income as a Percent of Poverty Level ([Figure 27, 3](#))
 - d. Primary Third Party Payment Source ([Figure 27, 4](#))

IMPORTANT NOTES:

- Information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory Governing Board requirements. Data on race and/or ethnicity collected on this form will not be used as an awarding factor.
- When entering data, the total Service Area Numbers and the total Target Population Numbers of the Race, Hispanic or Latino Ethnicity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source sections should be equal.

2. In order to automatically calculate the Total Service Area Numbers and Total Target Population Numbers for all four sections, click on the Save and Calculate Total button ([Figure 27, 8](#)) under any of the sections.
3. Under the **Special Populations** section ([Figure 27, 5](#)), enter the Service Area Number and the corresponding Target Population Number to each population group listed. Individuals may be counted in multiple special population groups, so the numbers in this section do not have to match those in the other sections of this form.

IMPORTANT NOTES:

- If you select the sub programs related to special populations (i.e. MHC, HCH and/or PHPC) in the [Budget Information – Section A–C](#) form of this application, you must provide a value greater than zero (0) for the Service Area Number and Target Population Number for the corresponding ‘Migratory/Seasonal Agricultural Workers and Families,’ ‘Homeless,’ and ‘Residents of Public Housing’ line item(s).
- In the ‘Other’ row ([Figure 27, 9](#)), applicants may specify a special population group that is not listed if desired, and then enter the Service Area Number and the corresponding Target Population Number for the specified special population group.
- The applicant can view the population percentages in the [Review – Program Specific Forms](#) section prior to submitting the application.

4. After completing all the sections on **Form 4**, click the Save and Continue button to save your work and proceed to the next form.

3.4 Form 1B: Funding Request Summary

In **Form 1B: Funding Request Summary**, you are required to distribute the **Total Federal Funds** that you requested for Year 1 among the grant program functions/sub-programs.

Figure 28: Form 1B: Funding Request Summary

Form 1B - Funding Request Summary

Note(s):

- Before completing Form 1B, the SF-424A: Budget Information form must be completed. The one-time funding request on Form 1B must be consistent with the SF-424A Construction and Equipment line items.
- If you select 'Equipment only' option in 'One-time funds will be used for' section below, you will be required to provide information in following form: Equipment List.
- If you select 'Minor alteration/renovation with equipment' option in 'One-time funds will be used for' section below, you will be required to provide information in following forms: Equipment List, Alteration/Renovation (A/R) Project Cover Page and Other Requirements for Sites.
- If you select 'Minor alteration/renovation without equipment' option in 'One-time funds will be used for' section below, you will be required to provide information in following forms: Alteration/Renovation (A/R) Project Cover Page and Other Requirements for Sites.
- If you select 'N/A' option in 'One-time funds will be used for' section below, you must not provide any information in following forms: Equipment List, Alteration/Renovation (A/R) Project Cover Page and Other Requirements for Sites.

Due Date: 8/14/2018 (Due In: 12 Days) | Section Status: Not Started

Resources

Fields with * are required

View Resources

- Refer to Section A – Budget Summary in Budget Information form to view the Total Federal Funds requested for Year 1.
- Refer to Section E – Budget Estimates Of Federal Funds Needed For Balance Of The Project in Budget Information form to view the Total Federal Funds requested for Year 2.
- Refer to Section B – Budget Categories in Budget Information form to view the Federal funds requested for Equipment and Construction (A/R).

Federal Funds Requested: Based on a 12-month Budget for each Budget Period

Type of Health Center	Program	Year 1 Operational	Year 2 Operational	Funding Population Percentage
* Community Health Centers	CHC-330(e)		\$0.00	0%
* Health Care for the Homeless	HCH-330(h)		\$0.00	0%
Migrant Health Centers	MHC-330(g)	\$0.00	\$0.00	0%
Public Housing Primary Care	PHPC-330(i)	\$0.00	\$0.00	0%
Total Operational Costs	Calculate	\$0.00	\$0.00	
* One-Time Funding			\$0.00	
Total Federal Funding Requested	Calculate	\$0.00	\$0.00	

If you indicate below that you are using one-time funds for A/R, you will be required to complete the applicable Site forms. After providing information in Form 5B, Equipment List, A/R Project Cover Page, or Other Requirements for Sites forms, if you choose to update the selected option displayed below, the system will delete information from all the forms that are not applicable.

*** One-time funds will be used for**

☐ Equipment only
☐ Minor alteration/renovation with equipment
☐ Minor alteration/renovation without equipment
☐ N/A

Go to Previous Page Save Save and Continue

- For each sub-program you are proposing to serve, enter **Operational Funds** (Figure 28, 1) for Year 1.
- Enter an amount for **One-Time Funding** for Year 1 (Figure 28, 2), if appropriate.

IMPORTANT NOTES:

- Before completing this form, the [SF-424A: Budget Information](#) forms must be completed. You must request Operational Funds that are greater than \$0 for every sub-program you selected in the [Section A – Budget Summary](#) form in the standard section of this NAP application.

- You may request One-Time Funding for Year 1 of up to \$150,000. If requested, the One-Time Funding amount must match the sum of the 'Equipment' and 'Construction' rows in the [Section B – Budget Categories](#) form in the standard section of this NAP application.
- The combined total of the Operational Funds and the One-Time Funding for Year 1 must not exceed the NAP maximum funding amount of \$650,000.
- The combined total of the Operational Funds and the One-Time Funding for Year 1 must be equal to the Total Federal funds requested in the [Section A – Budget Summary](#) form in the standard section of this NAP application.

3. If you entered an amount for **One-Time Funding**, click the **One-time funds will be used for:** radio button ([Figure 28, 3](#)) that describes how you will use the funds (Equipment only, Minor alteration or renovation with equipment, or Minor alteration or renovation without equipment). You should select the "N/A" radio button if you are not requesting **One-Time Funding**.

IMPORTANT NOTES:

- If you indicated that you will use the One-Time Funding for 'Equipment only' purpose, you must provide the necessary information in the [Equipment List](#) form of this application.
- If you indicated that you will use the One-Time Funding for 'Minor alteration/renovation with equipment' purpose, you must provide the necessary information in the [Alteration/Renovation \(A/R\) Information](#) and [Equipment List](#) forms of this application.
- If you indicated that you will use the One-Time Funding for 'Minor alteration/renovation without equipment' purpose, you must provide the necessary information in the [Alteration/Renovation \(A/R\) Information](#) form that includes the **A/R Project Cover page** and **Other Requirements for Sites** forms of this application.
- If you indicated that you are not requesting One-Time Funding by selecting the 'N/A' option, you will NOT be able to provide any information in the Alteration/Renovation (A/R) Information and Equipment List forms.
- If you update the radio button selection in **One-time funds will be used for:** section at any time and save the new selection, the system will delete the information provided by you in all forms that no longer apply based on the new selection.

4. Year 2 **Operational Funds** in **Form 1B** will be pre-populated with the federal funds requested for the first future funding year in the [Section E - Budget Estimates of Federal Funds Needed for Balance of the Project](#) form in the standard section of this NAP application ([Figure 28, 4](#)).

IMPORTANT NOTES:

- In **Form 1B**, you will not be able to edit the information pre-populated from the standard section of the NAP application. If you need to edit this information, navigate to the [SF-424A: Budget Information](#) section of this application.
- Operational Funds requested for Year 2 for every sub-program you selected in the standard section of the application must be greater than \$0.
- Total Operational Funds requested for Year 2 should not exceed the yearly NAP maximum funding amount of \$650,000.
- You cannot request One-Time Funding for Year 2.

5. Click the Save and Continue button at the bottom of the screen, to save your work and proceed to the next form.

3.5 Form 2: Staffing Profile

Form 2: Staffing Profile reports the personnel supported by the total budget for the proposed project. For each budget period (Year 1 and Year 2), the form has the following sections:

- [Staffing Positions by Major Service Category](#) sections
 - Administration/Management (**Figure 29, 1**)
 - Facility and Non-Clinical Support Staff (**Figure 29, 2**)
 - Physicians (**Figure 29, 3**)
 - NP, PA, and CNMs (**Figure 29, 4**)
 - Medical (**Figure 29, 5**)
 - Dental Services (**Figure 29, 6**)
 - Behavioral Health (Mental Health and Substance Abuse) (**Figure 30, 7**)
 - Professional Services (**Figure 30, 8**)
 - Vision Services (**Figure 30, 9**)
 - Pharmacy Personnel (**Figure 30, 10**)
 - Enabling Services (**Figure 30, 11**)
 - Other Programs and Services (**Figure 30, 12**)
- [Total FTEs](#) (**Figure 30, 13**)

Figure 29: Form 2- Staffing Profile

Form 2 - Staffing Profile

Note(s):

- Allocate staff time by function among the staff positions listed. An individual's full-time equivalent (FTE) should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time medical director should be listed in each respective category, with the FTE percentage allocated to each position (e.g., CMO 30% FTE and family physician 70% FTE). Do not exceed 100% FTE for any individual. Refer to the [2015 UDS manual](#) for position descriptions.

Due Date: 10/15/2016 (Due In: 10 Days) | **Section Status:** Not Started

Resources

Year 1 **Year 2**

Fields with * are required

Administration/Management

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Executive Director/CEO		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Finance Director/Chief Fiscal Officer/CFO		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Chief Operating Officer/COO		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Chief Information Officer/CIO		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Medical Director/Chief Medical Officer/CMO		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Administrative Support Staff		<input type="radio"/> Yes <input checked="" type="radio"/> No

Facility and Non-Clinical Support Staff

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Fiscal and Billing Staff		<input type="radio"/> Yes <input checked="" type="radio"/> No
* IT Staff		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Facility Staff		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Patient Support Staff		<input type="radio"/> Yes <input checked="" type="radio"/> No

Physicians

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Family Physicians		<input type="radio"/> Yes <input checked="" type="radio"/> No
* General Practitioners		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Internist		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Obstetrician/Gynecologist		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Pediatricians		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Specialty Physicians Please Specify:		<input type="radio"/> Yes <input checked="" type="radio"/> No
(Maximum 40 characters)		

NP, PA, and CNMs

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Nurse Practitioners		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Physician Assistants		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Certified Nurse Midwives		<input type="radio"/> Yes <input checked="" type="radio"/> No

Medical

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Nurses		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Medical Personnel (e.g. Medical Assistants, Nurse Aides)		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Laboratory Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No
* X-Ray Personnel		<input type="radio"/> Yes <input checked="" type="radio"/> No

Dental Services

Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Dentists		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Dental Hygienists		<input type="radio"/> Yes <input checked="" type="radio"/> No
* Dental Assistants, Aides, Technicians		<input type="radio"/> Yes <input checked="" type="radio"/> No

Figure 30: Form 2- Staffing Profile continued...

▼ Behavioral Health (Mental Health and Substance Abuse) 7		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Psychiatrists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Licensed Clinical Psychologists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Licensed Clinical Social Workers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Mental Health Staff Please Specify: <input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
(Maximum 40 characters)		
* Other Licensed Mental Health Providers Please Specify: <input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
(Maximum 40 characters)		
* Substance Abuse Providers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
▼ Professional Services 8		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Other Professional Health Services Staff Please Specify: <input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
(Maximum 40 characters)		
▼ Vision Services 9		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Ophthalmologists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Optometrists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Vision Care Staff Please Specify: <input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
(Maximum 40 characters)		
▼ Pharmacy Personnel 10		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Pharmacy Personnel	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
▼ Enabling Services 11		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Case Managers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Patient/Community Education Specialists	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Outreach Workers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Transportation Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Eligibility Assistance Workers	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Interpretation Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Other Enabling Services Staff Please Specify: <input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
(Maximum 40 characters)		
▼ Other Programs and Services 12		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Other Programs and Services Staff Please Specify: <input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
(Maximum 40 characters)		
▼ Total FTEs 13		
Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals ⓘ <input type="button" value="Calculate"/>	0	N/A
<input type="button" value="Go to Previous Page"/> <input type="button" value="Save"/> <input type="button" value="Save and Continue"/>		

3.5.1 Completing the Staffing Positions by Major Service Category related sections

1. In the Direct Hire FTEs column, provide only the number of Full Time Employees (FTEs) directly hired by the health center for each staffing position. Enter zero (0) if not applicable (Figure 31, 1).
2. In the Contract/Agreement FTEs column, indicate whether contracts are used for specific provider categories. (Figure 31, 2).
3. If both direct hire staff and contracts are used, provide the number of Direct Hire FTEs only and check Yes in the Contract/Agreement FTEs column.

IMPORTANT NOTES:

- Allocate staff time in the Direct Hire FTE column by function among the staff positions listed. An individual's FTE should not be duplicated across positions. For example, a provider serving as a part-time family physician and a part-time Clinical Director should be listed in each respective category with the FTE percentage allocated to each position (e.g., CMO 0.3 FTE and family physician 0.7 FTE). Do not exceed 1.0 FTE for any individual.
- For position descriptions, refer to the UDS Reporting Manual (<http://bphc.hrsa.gov/datareporting/reporting/2015udsmanual.pdf>).
- Record volunteers in the Direct Hire FTEs column.

Figure 31: Direct Hire and Contract/Agreement FTEs columns

▼ Administration/Management		
Staffing Positions for Major Service Category	Direct Hire FTEs ¹	Contract/Agreement FTEs ²
* Executive Director/CEO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Finance Director/Chief Fiscal Officer/CFO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Chief Operating Officer/COO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Chief Information Officer/CIO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Clinical Director/Chief Medical Officer/CMO	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Administrative Support Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
▼ Facility and Non-Clinical Support Staff		
Staffing Positions for Major Service Category	Direct Hire FTEs	Contract/Agreement FTEs
* Fiscal and Billing Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* IT Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Facility Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Patient Support Staff	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

3.5.2 Completing the Total FTEs section

This row displays the sum of 'Direct Hire FTEs' for the Staffing Positions by Major Service Categories.

1. To calculate the totals, click on the Calculate button (Figure 32).

Figure 32: Total FTEs

Total FTEs		
Totals	Direct Hire FTEs	Contract/Agreement FTEs
Totals ⓘ Calculate	0	N/A
Go to Previous Page		Save Save and Continue

- Click the Save and Continue button to save your work and proceed to **Form 2: Staffing Profile** for Year 2.

3.5.3 Completing Year 2 of Form 2: Staffing Profile

To complete Year 2 of the **Form 2: Staffing Profile**, repeat the steps above from sections [3.5.1](#) and [3.5.2](#) in the same manner as Year 1. When finished, click the Save and Continue button to save your work and proceed to the next form.

IMPORTANT NOTE: **Form 2: Staffing Profile** will be complete only when the status for both Year 1 and Year 2 sections are complete. The completed status of each of these sections is indicated with a green check mark (✓ icon) in the section tabs.

3.6 Form 3: Income Analysis

Form 3: Income Analysis projects program income, by source, for the proposed project. For each budget period (Year 1 and Year 2), the form has the following sections:

- [Payer Category](#) ([Figure 33, 1](#))
- [Comments/Explanatory Notes](#) ([Figure 33, 2](#))

Figure 33: Form 3: Income Analysis

Form 3 - Income Analysis

Note(s):
The value in the Projected Income (d) column should equal the value in the Billable Visits (b) column multiplied by the value in the Income per Visit (c) column. If not, explain in the Comments/Explanatory Notes box.

Due Date: 07/15/2017 (Due In: 90 Days) | Section Status: Not Started

Resources

Year 1 **Year 2**

* are required

Payer Category ¹	Patients By Primary Medical Insurance (a) ³	Billable Visits (b) ⁴	Income Per Visit (c) ⁵	Projected Income (d) ⁶	Prior FY Income ⁷
Part 1: Patient Service Revenue - Program Income					
* 1. Medicaid					
* 2. Medicare					
* 3. Other Public					
* 4. Private					
* 5. Self Pay					
6. Total (Lines 1 - 5) Calculate Total and Save ⁸	0	0	N/A	\$0	\$0
Part 2: Other Income - Other Federal, State, Local and Other Income					
* 7. Other Federal	N/A	N/A	N/A		
* 8. State Government	N/A	N/A	N/A		
* 9. Local Government	N/A	N/A	N/A		
* 10. Private Grants/Contracts	N/A	N/A	N/A		
* 11. Contributions	N/A	N/A	N/A		
* 12. Other	N/A	N/A	N/A		
* 13. Applicant (Retained Earnings)	N/A	N/A	N/A		
14. Total Other (Lines 7 - 13) Calculate Total and Save ⁸	N/A	N/A	N/A	\$0	\$0
Total Non-Federal (Non-Health Center Program) Income (Program Income Plus Other)					
15. Total Non-Federal Income (Lines 6 + 14) Calculate Total and Save ⁹	N/A	N/A	N/A	\$0	\$0
Comments/Explanatory Notes (if applicable) ²					
Approximately 2 pages (Max 2500 Characters): 2500 Characters left.					

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

3.6.1 Completing the Payer Category section

The Payer Category section is further divided into the following sub-sections:

- Part 1: Patient Service Revenue - Program Income
- Part 2: Other Income - Other Federal, State, Local and Other Income
- Total Non-Federal (Non-Health Center Program) Income (Program Income Plus Other)

To complete the **Payer Category** section, follow the steps below:

1. In column (a), project the number of Patients by Primary Medical Insurance for each Payer Category in Part 1. Enter 0 if not applicable ([Figure 33, 3](#)).

2. In column (b), project the number of Billable Visits for each Payer Category in Part 1. Billable Visits should be greater than or equal to the number of Patients by Primary Medical Insurance in column (a). Enter zero (0) if not applicable ([Figure 33, 4](#)).
3. In column (c), provide the amount of Income per Visit for each Payer Category in Part 1. Enter zero (0) if not applicable. ([Figure 33, 5](#)).
4. In column (d), calculate the amount of Projected Income for each Payer Category in Parts 1 and 2. Enter zero (0) if not applicable ([Figure 33, 6](#)).
5. In column (e), provide the amount of Prior FY Income for each Payer Category in Parts 1 and 2. Enter zero (0) if not applicable ([Figure 33, 7](#)).
6. Click the Calculate Total and Save button to calculate and save the values for each Payer Category in Parts 1 and 2. ([Figure 33, 8](#)).

IMPORTANT NOTES:

- The value in the Projected Income (d) column should equal the value in the Billable Visits (b) column multiplied by the value in the Income per Visit (c) column. If these values are not equal, provide an explanation in the [Comments/Explanatory Notes](#) box.
- The Patients By Primary Medical Insurance (a), Billable Visits (b) and Income Per Visit (c) columns in Part 2 are disabled and set to 'N/A'.

7. Click the Calculate Total and Save button in the **Total Non-Federal (Non-Health Center Program) Income (Program Income plus Other)** section to calculate and save Total Non-Federal Income. ([Figure 33, 9](#)).

3.6.2 Completing the Comments/Explanatory Notes section

In this section, enter any comments/explanations related to this form.


1. As applicable, provide an explanation for each Payer Category for which Projected Income (d) is not equal to the value obtained by multiplying Billable Visits (b) with Income per Visit (c).
2. Note significant exclusions and/or additions to the Billable Visits data in the comments box.
3. Click Save and Continue to save your work and proceed to **Form 3: Income Analysis** for Year 2.

3.6.3 Completing Year 2 of Form 3: Income Analysis

To complete Year 2 of the **Form 3: Income Analysis**, repeat the steps above from sections [3.6.1](#) and [3.6.2](#) in the same manner as Year 1. When finished, click the Save and Continue button to save your work and proceed to the next form.

IMPORTANT NOTES:

- Information provided for Year 1 will not be carried over to Year 2. Consider printing information you provide for Year 1 as reference to provide information for Year 2.

- **Form 3: Income Analysis** will be complete only when the status for both Year 1 and Year 2 sections are complete. The completed status of each of these sections is indicated with a green check mark ( icon) in the section tabs.

3.7 Form 5A: Services Provided

Form 5A – Services Provided identifies the services to be provided, and how they will be provided by the applicant organization. HRSA permits organizations to provide required services directly, by contracting with another provider, or by referral to another provider. These modes of service provision differ according to the service provider and the payment source (**Table 1**). See the Form 5A Column Descriptors at <http://bphc.hrsa.gov/programrequirements/scope.html> for descriptions and requirements for using each of the three service delivery modes.

Table 1: Modes of Service Provision

Mode of Service Provision	Your Organization Provides the Service	Your Organization Pays for the Service
1. Column I - Direct (Figure 34, 3)	Yes	Yes
2. Column II - Formal Written Contract/Agreement (Figure 34, 4)	No	Yes
3. Column III - Formal Written Referral Arrangement (Figure 34, 5)	No	No

Form 5A – Services Provided has the following two sections:

- [Required Services](#) (**Figure 34, 1**)
- [Additional Services](#) (**Figure 34, 2**)

Figure 34: Form 5A – Services Provided (Required Services)

Form 5A - Services Provided (Required Services)

Note(s):
Select Service Delivery Methods for required services as applicable to the proposed NAP project.

Due Date: 10/15/2018 (Due In: 88 Days) | Section Status: Not Started

Resources

Fields with * are required

Required Services **Additional Services**

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT pay)
* General Primary Medical Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Diagnostic Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Diagnostic Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Screenings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Coverage for Emergencies During and After Hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Voluntary Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Well Child Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Gynecological Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrical Care			
* Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Intrapartum Care (Labor & Delivery)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Postpartum Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Preventive Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Pharmaceutical Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* HCH Required Substance Abuse Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Eligibility Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Health Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Outreach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Translation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Go to Previous Page Save Save and Continue

3.7.1 Completing the Required Services Section

To complete this section of **Form 5A**, follow the instructions below:

1. Check one or more boxes to indicate the service delivery mode(s) for each of the required services as applicable to the proposed NAP project (Figure 34, 3-5). See the Form 5A Service Descriptors at <http://bphc.hrsa.gov/programrequirements/scope.html> for descriptions of the general elements for all services.
2. Click the Save and Continue button to navigate to the **Additional Services** section OR click the Save button on the **Required Services** Section and select the **Additional Services** tab (Figure 34, 2).

IMPORTANT NOTES:

- You must select Column I and /or Column II for the 'General Primary Medical Care' (**Figure 34, 6**) service row for your application to be eligible for funding.
- If you are applying to receive "Health Care for the Homeless" (HCH) sub program funding, as noted in the Budget Information: [Section A - Budget Summary](#) section of this application, you must have Column I and/or Column II selected for the 'HCH Required Substance Abuse Services' service row (**Figure 34, 7**) in the Required services section for your application to be eligible for funding. If you are not requesting HCH sub program funding, this row will be disabled in your application.

3.7.2 Completing the Additional Services Section

The Additional Services section of **Form 5A** is optional. You are not required to identify modes of provision for any additional services listed in this section. However, if additional services will be provided through the proposed NAP project, follow the instructions below to complete this section of **Form 5A**:

1. Check one or more boxes to indicate the service delivery mode(s) for additional services as applicable to the proposed NAP project (**Figure 34**).

IMPORTANT NOTE: If you are not applying to receive HCH sub program funding, as noted in the Budget Information: [Section A - Budget Summary](#) section of this application, you will not be able to select 'HCH Required Substance Abuse Services' in the Required Services section. However, you may select 'Substance Abuse Services' in the Additional Services section (**Figure 35, 1**).

Figure 35: Form 5A – Services Provided (Additional Services)

Form 5A - Services Provided (Additional Services)

Note(s):
Select Service Delivery Methods for additional services as applicable to you. If you do not wish to propose Service Delivery Methods for any of the additional services listed below, click on 'Save' or 'Save and Continue' button at the bottom of this section.

Due Date: 10/15/2018 (Due In: 30 Days) | **Section Status:** Not Complete

Resources

Fields with * are required

Required Services **Additional Services**

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT pay)
Additional Dental Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health Services			
Mental Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recuperative Care Program Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech-Language Pathology/Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complementary and Alternative Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Enabling/Supportive Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

- After completing all the sections on **Form 5A**, click the Save and Continue button to save your work and proceed to the next form.

3.8 Form 5B: Service Sites

Form 5B: Service Sites identifies the sites where you will provide services and/or perform administrative tasks for the NAP project.

You will be able to propose the following types of sites in this form:

- Service Delivery Site
- Administrative/Service Delivery Site
- Admin-only Site

IMPORTANT NOTE: You are required to propose at least one 'Service Delivery' or 'Administrative/Service Delivery' site in the NAP application.

To propose a new site, follow the steps below:

1. Click the Add New Site button (**Figure 36**) provided above the **Proposed Sites** section.

Figure 36: Add New Site Button

Form 5B - Service Sites

Note(s):

- If you are proposing to serve Community Health Centers, Public Housing Health Centers or Homeless Health Centers with or without Migrant Health Centers, you must propose at least one new Service Delivery site or Administrative/Service Delivery site with Location Type as 'Permanent' and operating for at least 40 hours.
- If you are proposing to serve only Migrant Health Centers, you must propose at least one new Service Delivery site or Administrative/Service Delivery site with Location Type as 'Permanent' or 'Seasonal' and operating for at least 40 hours.

PROPOSED SITES Due Date: 10/15/2017 (Due In: 99 Days) | Section Status: Not Started

Resources

Add New Site 1

Proposed Sites

No sites added

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

➤ The system navigates to the **Service Site Checklist** page.

2. Answer the questions displayed on the **Service Site Checklist** page.

IMPORTANT NOTES:

- If the answer to question 1 is 'No' (**Figure 37, 1**), i.e. if the site being added is not an 'Admin-only' site,
 - > To qualify as a service site, select 'Yes' for questions 'a' through 'd', AND
 - > Indicate if the site being added is a domestic violence site by answering 'Yes' or 'No' to question 2 (**Figure 37, 2**). Domestic Violence site is a confidential site serving victims of domestic violence and the site address cannot be published due to the necessity to protect the location of the domestic violence shelter.
- If the answer to question 1 is 'Yes' (**Figure 37, 1**), i.e. if the site being added is an 'Admin-only' site, questions the remaining questions are not applicable.

Figure 37: Service Site Checklist page

Service Site Checklist

Due Date: 8/15/2018 (Due In: 81 Days)

Resources

Fields with * are required

Site Qualification Criteria

* 1. Is the site an "admin-only" site? 1

If Yes, the site is an 'Admin-only' site, select 'Not Applicable' for questions 'a' to 'd' below. If No, the site is a Service Delivery site, answer questions 'a' to 'd' Yes or No.

a. Are/will health center visits be generated by documenting in the patients records face-to-face contacts between patients and providers? ☐ Yes ☐ No ☒ Not Applicable

b. Do/will providers exercise independent judgment in the provision of services to the patient? ☐ Yes ☐ No ☒ Not Applicable

c. Are/will services be provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location? ☐ Yes ☐ No ☒ Not Applicable

d. Are/will services be provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month)? ☐ Yes ☐ No ☒ Not Applicable

* 2. Is the site a Domestic Violence (Confidential) shelter? 2 ☐ Yes ☒ No ☐ Not Applicable

[Go to Previous Page](#) 3 [Verify Qualification](#)

3. Click the Verify Qualification button (Figure 37, 3).
 - The system navigates to the **List of Pre-registered Performance Sites at HRSA Level** page displaying all the sites that are registered by your organization within EHB.
4. To use a new location for the site you are proposing in **Form 5B**, click the Register Performance Site button (Figure 38, 1) and register your site using the Enterprise Site Repository (ESR) system by following the steps below:
 - On the Basic Information – Enter page, provide a site name and select a site type from the following options: Fixed or Mobile. Click the Next Step button.
 - On the Address – Enter page, enter the physical address of the site. The NAP funding opportunity requires you to provide a verifiable physical street address when registering a new site for your application. Click the Next Step button.
 - On the Register – Confirm page, the system displays physical address you entered on the Address – Enter page along with the standardized format of the address. Select the option you want and click the Confirm button.
 - On the Register – Result page, click the Finish button to finally register the site to your organization.

Figure 38: List of Pre-registered Performance Sites at HRSA Level page

List of Pre-registered Performance Sites at HRSA Level

Note(s):

- Click on 'Register Performance Site' to register a new Performance Site at HRSA level. Select a site and click on 'Update the Registered Performance Site' button to update the site information. Select a site and click on 'Select This Location' button to complete adding the site.
- Ensure that the Site Address of the selected site is accurate before adding it to your NAP application. To be eligible, sites must have a street address.

Due Date: 10/15/2018 (Due In: 80 Days)

Resources

Register Performance Site 1

Site Name	Performance Site Type	Performance Site Address	Performance Site Address Category	Options
Trinity Richmond	Fixed	4021 Kennedy Rd, West Richmond, VA 23093-7100	Accurate 3	2 Select Site Location
Trinity-Lexington	Fixed	867 Stage Boulevard STE 201-202, Richmond, VA 23062	Accurate	Select Site Location
Trinity Community Health-Peace Medical	Fixed	818 N Court St, Peace, VA 23081-0707	Accurate	4 Select Site Location
Richmond	Fixed	1111 Bank, Richmond, VA 23011	Accurate	Select Site Location
Trinity - Peace Medical	Fixed	818 N Court St, Peace, VA 23081-0707	Accurate	Select Site Location
Trinity Medical Community Center	Fixed	800 N. Virginia St., Farmville, VA 23040-6001	Approximate	Select Site Location
Trinity - Lexington Community Center	Fixed	1018 N. Courthouse Ave STE 6, Farmville, VA 23040-1018	Accurate	Select Site Location
Trinity-Peace Community Center	Fixed	1122 S 7th Ave, Peace, VA 23081-0706	Accurate	Select Site Location

Cancel

- Select a site for the NAP from the list of pre-registered performance sites and click its **Select Site Location** link (Figure 38, 2). Standardized addresses will be listed as “Accurate” (Figure 38, 3). If the address is “Approximate,” ensure that the site address entered is a verifiable physical street address.

IMPORTANT NOTE: The system disables the **Select Site Location** link (Figure 38, 4) for the sites under any of the categories mentioned below. You will not be able to select such a site location:

- If the site is already included in the current application.
- If the site is already in your Health Center Program scope or in another award recipient’s Health Center Program scope with active or pending verification status.
- If the site is a Mobile site and applicant is trying to propose an “Admin-only” site.
- If the site is a confidential site and the applicant is trying to propose a non-confidential/non-domestic violence site.
- If the site is a non-confidential site and the applicant is trying to propose a confidential/domestic violence site.

In any of these cases, the system provides you the reasons for which the site is disabled when you hover over the **Select Site Location** link (Figure 38, 4).

- If you wish to update the name of any site on the list of pre-registered performance sites, click the **Update the Registered Performance Site** link (Figure 39) and update the site name.

Figure 39: Update the Registered Performance Site link

List of Pre-registered Performance Sites				
Site Name	Performance Site Type ⓘ	Performance Site Address	Performance Site Address Category	Options
Test 1	Fixed	300 MAIN STREET/STAMFORD, VA 21107-2077	Accurate	Select Site Location ▼
Test 2	Fixed	507 LIBERTY STREET/STAMFORD, VA 21106-0713	Accurate	Select Site Location ▼
Test Site	Fixed	40000 Village park place/Stafford, VA 21155	Approximate	Select Site Location ▼
Test 1	Fixed	1412 HAZARD STREET/STAMFORD, VA 21105-0804	Accurate	Action Select Site Location Update the Registered Performance Site
Test 1 (update)	Fixed	40000 Village park place/Stafford, VA 21155	Accurate	

- When you click the **Select Site Location** link of a site, the system navigates to the **Form 5B: Edit** page where you must provide all the required information for the site (Figure 40). Fields marked with an asterisk (*) are required.

Form-5B : Edit

Note(s):
It is recommended that you save your work often (e.g., every 5 minutes) to avoid a loss of data due to unforeseeable technical issues.

Fields with * are required for all site types.

Site Information		Status: Not Started
* Name of Service Site <input type="text" value="Change Site Name"/>	* Site Physical Address <input type="text" value="Change Location"/>	
* Service Site Type Service Delivery Site ▼	* Site Phone Number () - Ext.	
* Web URL <input type="text"/>		
The following fields are required for "Service Delivery" and "Administrative/Service Delivery" site types, other than where exceptions are noted:		
* Location Type Select Location Type ▼	* Location Setting (Required for Service Site) Select Site Setting ▼	
Date Site was Added to Scope N/A	* Site Operational By <input type="text"/> [Calendar Icon]	
* FQHC Site Medicare Billing Number Status Select Medicare Billing Number Status ▼	Medicare Billing Number <input type="text"/>	
FQHC Site National Provider Identification (NPI) Number <input type="text"/>	* Total Hours of Operation when Patients will be Served per Week <input type="text"/>	
Months of Operation <input type="text"/>		
Saved Months of Operation <input type="text"/>		
Number of Contract Service Delivery Locations (Voucher Screening Only) <input type="text"/>	Number of Intermittent Sites (Intermittent Only) <input type="text"/>	
* Site Operated by Select Site Operated By ▼		

Add Subrecipient/Contractor

▼ Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By'... (+ View More))

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN	Options
No Subrecipient or Contractor information to be displayed			

Service Area Zip Code (Include only those from which the majority of the patient population will come)

* Service Area Zip Codes

[Save Zip Code\(s\)](#)

Saved Service Area Zip Code(s)

[Go to Previous Page](#)
[Save](#) [Save and Continue](#)

- If you are proposing to serve Community Health Center, Public Housing Primary Care, and/or Health Care for the Homeless (with or without Migrant Health Center), you must propose at least one Service Delivery site or Administrative/Service Delivery that has a Location Type as ‘Permanent’, and that is operating for at least 40 hours a week.
- If you are proposing to serve only Migrant Health Centers (based on the sub program you selected in the [Section A – Budget Summary](#) form), you must propose at least one Service Delivery site or Administrative/Service Delivery site that has a Location Type as “Permanent” or “Seasonal,” and that is operating for at least 40 hours a week.

FY 2017 New Access Points

- The name, address, and service site type populate from the list of pre-registered performance sites.
- Select a Location Setting (i.e., all other clinic types, hospital, or school) and Location Type (i.e., permanent, seasonal, or mobile van).
- Enter the date that the site will be or became operational. The date must be no more than 120 days after the project start date.
- Select the Medicare billing status and enter Medicare billing number, if applicable. Enter 'N/A' if you do not have a billing number.
- Enter the total hours of operation per week for the site
- Select whether the site is operated by the health center/applicant, contractor, or subrecipient.
- If the site is operated by a contractor or subrecipient, you must enter information about the operating organization.
- Enter the zip codes for the NAP service area. After each five zip codes entered, click Save Zip Codes, to save and add more, if applicable.

IMPORTANT NOTE: You must add the zip code included in the physical address of the site in the Service Area Zip Codes field of **Form 5B: Edit** page.

9. After providing the complete information on **Form 5B – Edit** page, click the **Save and Continue** button.
 - **Form 5B – Service Sites** list page opens with the newly added site displayed in the **Proposed Site** section ([Figure 41](#)).

Figure 41: Newly added site displayed under Proposed Sites section

Form 5B - Service Sites

Note(s):

- If you are proposing to serve Community Health Centers, Public Housing Health Centers or Homeless Health Centers with or without Migrant Health Centers, you must propose at least one new Service Delivery site or Administrative/Service Delivery site with Location Type as 'Permanent' and operating for at least 40 hours.
- If you are proposing to serve only Migrant Health Centers, you must propose at least one new Service Delivery site or Administrative/Service Delivery site with Location Type as 'Permanent' or 'Seasonal' and operating for at least 40 hours.

Success:
Site added Successfully

Due Date: 10/15/2018 (Due In: 10 Days) | **Section Status:** Complete

Resources

Add New Site

Proposed Sites

Site Name	Physical Address	Service Site Type	Location Type	Site Status	Performance Site Address Category	Options
11000-11000	4001 Kennedy Rd, West Baltimore, MD 21206-7100	Administrative/Service Delivery Site	Permanent	Complete	Accurate	Update

Go to Previous Page **Save** **Save and Continue**

- To add additional sites, follow the steps 1-9 above. Once you have completed all the sections of **Form 5B**, click the Save and Continue button to save your work and proceed to the next form.

3.9 Form 5C: Other Activities/Locations

IMPORTANT NOTE: This is an optional form. If you do not want to propose any other activities or locations in your application, you can click on the Save and Continue button provided at the bottom of the form to complete it.

Form 5C – Other Activities/Locations identifies other activities or locations associated with your NAP project. To add new activities or locations, follow the steps below:

- Click the Add New Activity/Location button provided at the top of the form (**Figure 42**).

Figure 42: Add New Activity/Location button

Add New Activity/Location

Activity Type	Description	Frequency	Type of Location	Status	Options
No other activities/locations added.					

Go to Previous Page **Save and Continue**

- The system navigates to the **Activity/Location - Add** page (**Figure 43**).

Figure 43: Activity/Location – Add page

Fields with * are required

Activity/Location Information

* Type of Activity Select Option
 If Other, Please Specify

* Frequency of Activity Approximately 1/2 page(s) (Max 600 Characters): 600 Characters left

* Description of Activity Approximately 1/2 page(s) (Max 600 Characters): 600 Characters left

* Type of Location(s) where Activity is Conducted Approximately 1/2 page(s) (Max 600 Characters): 600 Characters left

Cancel Save Save and Continue

2. Provide information in all the fields on this page and click the Save and Continue button.
 - The system navigates to the **Form 5C** list page displaying the newly added activity on the form (**Figure 44**). Once the activity is added, it can be updated or deleted as needed.

Figure 44: Activity/Location added

➕ Add New Activity/Location

Activity Type	Description	Frequency	Type of Location	Status	Options
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	All	
Hospital Admitting	Admitting patients to hospitals	Daily	Permanent	Complete	Update

Go to Previous Page Save and Continue

3. After completing **Form 5C**, click the Save and Continue button to save your work and proceed to the next form.

3.10 Alteration/Renovation (A/R) Information

IMPORTANT NOTES:

- If you requested One-Time Funding for Year 1 in [Form 1B: Funding Request Summary](#) and indicated that you will be using these funds for minor alteration and renovation (with or without equipment), you will be required to complete the Alteration/Renovation (A/R) Information form, consisting of the [Alteration/Renovation \(A/R\) Project Cover Page](#) and [Other Requirements for Sites](#) sections for at least one service site proposed in Form 5B of this NAP application.

- You must propose at least one ‘Service Delivery’ or ‘Administrative/Service Delivery’ site in [Form 5B: Service Sites](#) form of this application in order to complete the A/R Information form.
- If you did not request One-Time Funding for alteration and renovation in [Form 1B: Funding Request Summary](#), this form will not apply to you ([Figure 45](#)). If the form is not applicable to you, click the Continue button to proceed to the next form.

Figure 45: A/R Information Page – “Not Applicable” Message

When the **Alteration/Renovation (A/R) Information** form is applicable to you, the system populates all the ‘Service Delivery’ and ‘Administrative/Service Delivery’ sites you proposed in the [Form 5B – Service Sites](#) form of this NAP application ([Figure 46, 1](#)). Any ‘Administrative-only’ sites proposed in [Form 5B: Service Sites](#) will *not* be listed on the A/R Information page because you cannot use one-time funds to perform alteration or renovation of an ‘Administrative-only’ site. Follow the steps below to complete this form:

Figure 46: A/R Information Page when Applicable

1. Answer whether you are requesting federal one-time funding for minor alteration/renovation at each site by clicking “Yes” or “No” ([Figure 46, 2](#)).
2. For each site for which you clicked “Yes”, click the Update button ([Figure 46, 3](#)) to update the [Alteration/Renovation \(A/R\) Project Cover Page and Other Requirements for Sites](#) ([Figure 47](#)).

IMPORTANT NOTES:

- If you requested One-Time Funding for Year 1 in [Form 1B: Funding Request Summary](#) and indicated that you will be using these funds for minor alteration and renovation, you must answer ‘Yes’ for the one-time funding question for at least one site listed on this form.

- You will be required to complete the [Alteration/Renovation \(A/R\) Proposal Cover Page](#) and [Other Requirements for Sites](#) sections for each site for which you answer 'Yes' for the one-time funding question.
- You will not be able to provide A/R information for sites for which you answer 'No' for the one-time funding question.

3.10.1 Alteration/Renovation (A/R) Project Cover Page

1. On the **A/R Project Cover Page**, answer all the questions and attach the documents as requested. Fields and attachments marked with an asterisk (*) are required.
2. After you have completed the **A/R Project Cover Page** ([Figure 47](#)), click the Save and Continue button at the bottom of the screen to save your work and proceed to the **Other Requirements for Sites** section.

IMPORTANT NOTE: For the Environmental Information Documentation (EID) checklist, download the template to your computer, complete the form, and attach it to your application in the form.

Figure 47: A/R Project Cover Page

Alteration/Renovation (A/R) Project Cover Page

Due Date: **10/10/2018** (Due In: 34 Days) | Section Status: Not Started

Resources

Fields with * are required

Alteration/Renovation (A/R) Project Cover Page **Other Requirements for Sites**

*** 1. Site Information**

Name of Service Site	Albany Area Primary Health Care
Site Address	800 N. Westover Blvd Albany, GA 31707-2100
Improved Project Square Footage	

*** 2. Project Description**

Provide a detailed description of the scope of work for the A/R project. Identify the major clinical and non-clinical spaces that will result from the project. Include the area (in square feet) or dimensions of the spaces to be altered, or renovated. The description should also list major improvements, such as permanently affixed equipment to be installed; modifications and repairs to the building exterior (including windows); heating, ventilation and air conditioning (HVAC) modifications (including the installation of climate control and duct work); electrical upgrades; plumbing work; and any work outside the building. Describe how the applicant will reduce the project's potential adverse impacts on the environment. Indicate whether or not the project will implement green/sustainable design practices/principles (e.g., using project materials, design/renovation strategies, equipment selection, etc.).

Approximately 2 pages (Max 4000 Characters): 4000 Characters left.

Design **Preview**

*** Attachments**

A/R Budget Justification (Minimum 1) (Maximum 1) **Attach File**

No documents attached

Environmental Information Documentation (EID) Checklist

Download Template

Name	Description	Options
EID Checklist	Template for EID Checklist	Download

EID Checklist (Minimum 1) (Maximum 1) **Attach File**

No documents attached

Floor Plans/Schematic Drawings (Minimum 1) (Maximum 2) **Attach File**

No documents attached

Other Project Documents (Minimum 0) (Maximum 1) **Attach File**

No documents attached

Go to Previous Page **Save** **Save and Continue**

3.10.2 Other Requirements for Sites

Applicants requesting one-time funding for minor alteration/renovation must complete the **Other Requirements for Sites** form for each site where minor alteration/renovation activities will occur. This form addresses site control, federal interest, and cultural resources and historic preservation considerations related to the A/R project. To complete this form:

1. Answer all of the questions on the form.
2. If the site is a leased property, you must attach a Landlord Letter of Consent in the Attachments section. Otherwise, do not upload any document in the Attachments section.

3. Click the Save and Continue button at the bottom of the form.

- You will be returned to the **A/R Information Page** with the list of proposed sites.

Figure 48: Other Requirements for Sites

The screenshot shows a web form titled "Other Requirements for Sites". At the top, there are two tabs: "Alteration/Renovation (A/R) Project Cover Page" and "Other Requirements for Sites". The form is divided into several sections:

- Site Information:** Contains fields for "Name of Service Site" (Albany Area Primary Health Care) and "Site Address" (600 N. Washington Blvd Albany, GA 31707-0100).
- * 1. Site Control and Federal Interest:**
 - 1a. Identify current status of property site (If 'Leased', please answer Question 1b)**
 - Radio buttons for "Owned" and "Leased".
 - 1b. If Leased, please check the following:**
 - Checkbox: "The applicant certifies the following:"
 - The existing lease will provide the health center reasonable control of the project site;
 - The existing lease is consistent with the proposed scope of project;
 - We understand and accept the terms and conditions regarding Federal Interest in the property.
- * 2. Cultural Resource Assessment and Historic Preservation Considerations:**
 - 2a. Was the project facility constructed prior to 1975?**
 - Radio buttons for "Yes" and "No".
 - 2b. Is the project facility 50 years or older?**
 - Radio buttons for "Yes" and "No".
 - 2c. Does any element of the overall work at the project site include:**
 - 1. Any renovation/modifications to the exterior of the facility (for example: roof, HVAC, windows, siding, signage, exterior painting, generators, etc.) or
 - 2. Ground disturbance activity (for example: expansion of building footprint, parking lot, sidewalks, utilities, etc.)?
 - Radio buttons for "Yes" and "No".
 - 2d. Does the project involve renovation to a facility that is, or near a facility that is, architecturally, historically, or culturally significant; or is the site located on or near Native American, Alaskan Native, Native Hawaiian, or equivalent culturally significant lands?**
 - Radio buttons for "Yes" and "No".
- Attachments:**
 - Text: "If property status is 'Leased', applicant must provide Landlord Letter of Consent."
 - Dropdown menu: "Landlord Letter of Consent (Minimum 0) (Maximum 1)".
 - Text: "No documents attached".
 - Button: "Attach File".

At the bottom of the form, there are three buttons: "Go to Previous Page", "Save", and "Save and Continue".

4. After you have completed the A/R Information, click the Save and Continue button at the bottom of the form to save your work and proceed to the next form.

IMPORTANT NOTES:

- If you add a new 'Service Delivery' or an 'Administrative/Service Delivery' site in [Form 5B: Service Sites](#) after completing the A/R Information form, you will be required to revisit the A/R Information form to answer the one-time funding question for that site and provide the A/R information for the site, as applicable.

- If you remove a site from [Form 5B: Service Sites](#), then the site will be removed from the A/R Information form.

3.11 Form 6A: Current Board Member Characteristics

Form 6A: Current Board Member Characteristics provides information about your organization's current board members.

IMPORTANT NOTES:

- This form is optional if you selected "Tribal Indian" or "Urban Indian" as the Business Entity in [Form 1A: General Information Worksheet](#). You can click the Save or the Save and Continue button at the bottom of the page to proceed to the next form.
- If you chose a Business Entity other than "Tribal Indian" or "Urban Indian," you must enter all required information on **Form 6A**.
- If **Form 6A** is optional for you, but you choose to enter information, then you must enter all required information.

Applicants are required to list all the current board members and provide the requested details. For existing award recipients submitting a satellite NAP application, the system will pre-populate the board member information from the last awarded Health Center Program application. Applicants will have the option to update or delete the pre-populated information and add board members, as applicable.

To complete **Form 6A**, follow the steps below:

1. To add information for a board member, click the Add New Board Member button ([Figure 49, 1](#)). You must provide a minimum of 9 and maximum of 25 board members.

Figure 49: Form 6A Current Board Member Characteristics

Form 6A - Current Board Member Characteristics

Due Date: 07/01/2018 (Due In: 10 Days) | Section Status: Not Started

Resources

Fields with * are required

1 Add New Board Member

List of All Board Member(s)

Name	Current Board Office Position Held	Area of Expertise	>10% of income from health industry	Health Center Patient	Live or Work in Service Area	Special Population Representative	Options
John Smith		Graduate Student	No	Yes	Live, Work	No	2 Update
Jessica Ryan		Physician (Physician Practitioner) at Washington	Yes	No	Live, Work	No	Update
John Lee		Small Business Owner	No	Yes	Live, Work	No	Update
David Phillips		Graduate Student	No	Yes	Live	Yes (PHPC)	Update
Patricia Hernandez		Off of Business Strategy and Marketing at Boeing	No	No		No	Update
Marco Nguyen		Independent Small Business Owner	No	Yes	Work	No	Update

3

Patient Board Member(s) Classification

Gender Number of Patient Board Members

* Male

* Female

* Unreported/Declined to Report

Ethnicity Number of Patient Board Members

* Hispanic or Latino

* Non-Hispanic or Latino

* Unreported/Declined to Report

Race Number of Patient Board Members

* Native Hawaiian

* Other Pacific Islanders

* Asian

* Black/African American

* American Indian/Alaska Native

* White

* More Than One Race

* Unreported/Declined to Report

Note(s):
This section is ONLY required if you selected Public (non-Tribal or Urban Indian) as the Business Entity on Form 1A of this application. In all other cases, select N/A.

If you are a public organization/center, do the board members listed above represent a co-applicant board?

☐ Yes ☐ No ☒ N/A

If yes, ensure that the co-applicant agreement is included as Attachment 6 in the Appendices form of this application.

Go to Previous Page Save Save and Continue

➤ The system navigates to the **Current Board Member - Add** page (Figure 50).

2. Provide the required board member information on this page. Click the Save and Continue button to save the information and navigate back to the **Form 6A** list page (Figure 50, 1), or the Save and Add New button to save the information and add a new board member (Figure 50, 2).

Figure 50: Current Board Member – Add Page

Current Board Member - Add

Due Date: 12/31/2016 (Due In: 115 Days)

Resources

View

SAC FY 2016 User Guide | Funding Opportunity Announcement | SAC TA

Fields with * are required

Board Member Information

* First Name

* Last Name

Middle Initial

Current Board Office Position Held

* Area of Expertise

* Does member derive more than 10% of income from health industry ?

* Is member a health center patient ?

Live or work in service area ?

* Is member a special population representative (MHC, HCH, PHPC) ?

Yes No

Yes No

Live Work

Yes No

If Yes, please specify Special Population:

☐ Migrant Health (MHC)

☐ Homeless Health (HCH)

☐ Public Housing (PHPC)

Cancel

1 Save and Continue

2 Save and Add New

- To update or to delete information for any board member, click on **Update** or **Delete** link under the options column in the **List of All Board Members** section (**Figure 49, 2**).
- Enter the gender, ethnicity, and race of board members who are patients of the health center in the **Patient Board Member Classification** sections (**Figure 49, 3**).

IMPORTANT NOTES:

- The totals of each Patient Board Member Classification sections must be equal.
 - The total number of patient board members under each classification section should be less than or equal to the total number of board members added in the List of All Board Members section.
- If you selected Public (non-Tribal or Urban Indian) as the business entity in **Form 1A: General Information Worksheet** of this application, select 'Yes' or 'No' for the public organization/center related question. If you selected a different business entity in **Form 1A**, select 'N/A' for this question. If you answer 'Yes' to this question, ensure that the Co-applicant Agreement is included as **Attachment 6** in the **Appendices** form of this application.
 - After providing all of the necessary information on **Form 6A**, click the Save and Continue button to save the information and proceed to the next form.

3.12 Form 6B: Request for Waiver of Governance Requirements

If you are proposing to serve only Migrant Health Center, Health Care for the Homeless, and/or Public Housing Primary Care, **Form 6B** is used to request a waiver of the 51% patient majority governance

requirement. Note that HRSA will not grant a waiver request if your organization currently receives or is applying for Community Health Center (CHC) funding.

3.12.1 Completing Form 6B when it is not applicable

Form 6B will not be applicable in the following cases:

- You selected “Tribal” or “Urban Indian” as the Business Entity in [Form 1A: General Information Worksheet](#).
- You are currently receiving Community Health Centers (CHC) funding, or you selected CHC as one of the sub programs in the Budget Information: [Section A - Budget Summary](#) form of this application.

If the form is not applicable to you, click the Continue button to complete and proceed to the next form (Figure 51, 1).

Figure 51: Form 6B: Request for Waiver of Governance Requirements – Not Applicable

Form 6B - Request for Waiver of Governance Requirements

Due Date: 10/15/2016 (Due In: 99 Days) | Section Status: Complete

Resources

Alert:
This form is not applicable to you as you are currently receiving or applying to receive Community Health Centers (CHC) funding and/or you have selected 'Tribal' or 'Urban Indian' as the Business Entity in Form 1A.

Go to Previous Page

Continue

3.12.2 Completing Form 6B when it is applicable

To complete **Form 6B** when it is applicable and necessary for your organization, follow the steps provided below:

1. Indicate whether you are requesting a new waiver of the 51% patient majority governance requirement under the **New Waiver Request** section ([Figure 52, 1](#)) or if you currently have a waiver in the **For Applicants With Previous Waiver** section ([Figure 52, 2](#)).

Figure 52: Form 6B: Request for Waiver of Governance Requirements – Applicable

Form 6B - Request for Waiver of Board Member Requirements

Due Date: (Due In: Days) | Section Status:

▼ Resources

Fields with * are required

1. New Waiver Request

Name of Organization

1a. Are you requesting a new waiver of the 51% patient majority governance requirement? ☐ Yes ☐ No

2. For Applicants With Previous Waiver

* 2a. Do you currently have a waiver of the 51% patient majority governance requirement? ☐ Yes ☐ No

2b. Are you requesting the patient majority waiver to be continued? (This question is required if you answered "Yes" to question 2a.) ☐ Yes ☐ No (Governing Board is in Full Compliance) ☐ Not Applicable

3. Demonstration of Good Cause for Waiver (demonstrate good cause for the waiver request by addressing the following areas)

3a. Provide a description of the population to be served and the characteristics of the population/service area that would necessitate a waiver. (This question is required if you answered "Yes" to question 1 and/or question 2b.)

3b. Provide a description of the health center's attempts to meet the requirement to date and explain why these attempts have not been successful. (This question is required if you answered "Yes" to question 1 and/or question 2b.)

4. Alternative Mechanism Plan for Addressing Patient Representation

4a. Present a plan for complying with the intent of the statute via an alternative mechanism that ensures patient input and participation in the organization, as well as direction and ongoing governance of the health center. (This question is required if you answered "Yes" to question 1 and/or question 2b.)

Go to Previous Page Save Save and Continue

2. If you answered 'Yes' to question 2a, you must answer 'Yes' or 'No' for question 2b. Select 'N/A' for question 2b if you answered 'No' to question 2a.
3. If you answered 'Yes' to question 1 or question 2b, you must answer the remaining questions on the form.
4. After completing **Form 6B**, click the Save and Continue button to save your work and proceed to the next form.

3.13 Form 8: Health Center Agreements

Form 8 indicates whether you have or propose to make 1) any agreements with a parent, affiliate, or subsidiary organization; and/or 2) any subawards to subrecipients and/or contract with another organization to carry out a substantial portion of the proposed scope of project, including a proposed site to be operated by a subrecipient or contractor, as identified in [Form 5B: Service Sites](#). This form has the following sections:

- [Part I: Health Center Agreements](#) ([Figure 53, 1](#))
- [Part II: Adding Organization Agreement details](#) ([Figure 53, 2](#))

Figure 53: Form 8 – Health Center Agreements

Form 8 - Health Center Agreements

Note(s):
When a health center grantee wishes to establish an agreement/arrangement in the future that will either (1) result in another organization carrying out a substantial portion of the approved scope of project or (2) impact the governing board's composition, authorities, functions, or responsibilities, a Prior Approval request must be submitted in EHB and approved by HRSA before the agreement/arrangement can be formalized and implemented.

Due Date: 12/15/2016 (Due In: 30 Days) | Section Status: Not Started

Resources

View
SAC FY 2016 User Guide | Funding Opportunity Announcement | SAC TA

Fields with * are required

PART I Health Center Agreements

* 1. Does your organization have a parent, affiliate, or subsidiary organization ? ☐ Yes ☐ No

* 2. Do you have, or propose to make as part of this application any subawards to subrecipients and/or will you contract with another organization to carry out a substantial portion of the proposed scope of project? Contracts for a substantial portion of the award include contracting for the majority of core primary care services and/or health center key management positions (e.g., Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO)).

Note(s):

- Subawards or contracts made to related organizations such as a parent, affiliate, or subsidiary must also be addressed in this form.
- This form excludes contracts for the acquisition of supplies, material, equipment, or general support services (e.g., janitorial services, contracts with individual providers).

☐ Yes ☐ No

2a. Number of contracts for a substantial portion of the proposed scope of project for any of the following: the majority of core primary care services and/or health center key management positions (e.g., Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO))

(positive integer up to 4 digits)

2b. Number of subrecipients that will carry out a substantial portion of the proposed scope of project via a subaward

(positive integer up to 4 digits)

2c. Total number of contracts and/or subawards for a substantial portions of the proposed scope of project

Save and Calculate

Add Organization Agreement

Part II: Attachments

All affiliations/contracts/subawards referenced in Part I must be uploaded in full. Uploaded documents will NOT count against the page limit

No organization agreement details added

Go to Previous Page **Save** **Save and Continue**

3.13.1 Completing Part I: Health Center Agreements

To complete Part I of **Form 8**, follow the steps below:

1. Answer question 1 (**Figure 54, 1**) and question 2 (**Figure 54, 2**). Select 'Yes' for question 2 if any current or proposed agreements exist with another organization to carry out a substantial portion of your organization's approved scope of project.

IMPORTANT NOTE: If any of the new sites proposed in [Form 5B: Service Sites](#) are being operated by a "Subrecipient" or a "Contractor", the system will set the answer for question 2 to 'Yes'.

Figure 54: Form 8, Part I

Fields with * are required

PART I Health Center Agreements

* 1. Does your organization have a parent, affiliate, or subsidiary organization ? ☐ Yes ☐ No 1

* 2. Do you have, or propose to make as part of this application any subawards to subrecipients and/or will you contract with another organization to carry out a substantial portion of the proposed scope of project? Contracts for a substantial portion of the award include contracting for the majority of core primary care services and/or health center key management positions (e.g., Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO)).

Note(s):

- Subawards or contracts made to related organizations such as a parent, affiliate, or subsidiary must also be addressed in this form.
- This form excludes contracts for the acquisition of supplies, material, equipment, or general support services (e.g., janitorial services, contracts with individual providers).

☐ Yes ☐ No 2

2a. Number of contracts for a substantial portion of the proposed scope of project for any of the following: the majority of core primary care services and/or health center key management positions (e.g., Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO)) (positive integer up to 4 digits) 3

2b. Number of subrecipients that will carry out a substantial portion of the proposed scope of project via a subaward (positive integer up to 4 digits) 4

2c. Total number of contracts and/or subawards for a substantial portions of the proposed scope of project 5

- If 'Yes' was selected for question 2, complete questions 2a and 2b (Figure 54, 3-4). Click Save and Calculate to show the total number of contracts or subawards in 2c (Figure 54, 5).

3.13.2 Completing Part II: Adding Organization Agreement details

If you answered 'Yes' to questions 1 or 2, provide each agreement with external organizations as noted in [Part I](#). The agreements will be organized by organization. To add agreements, follow the steps below:

- Click the Add Organization Agreement button located above Part II (Figure 55, 1).

Figure 55: Form 8, Part II

1

Part II: Attachments

All affiliations/contracts/subawards referenced in Part I must be uploaded in full. Uploaded documents will NOT count against the page limit

No organization agreement details added

- The system navigates to the **Organization Agreement - Add** page (Figure 56).

Figure 56: Organization Agreement – Add page

2. Provide the required information for the agreement in the **Organization Agreement Detail** section on this page (Figure 56, 1).
3. Under the **Attachments** section at the bottom of this page, click on the Attach File button (Figure 56, 2) to upload at least one document related to the organization (i.e., the complete affiliation agreement, contract, and/or subaward).

IMPORTANT NOTE: Before uploading a document for Form 8, rename the file to include the affiliated organization's name (e.g., "CincinnatiHospital_MOA.doc").

4. Click Save and Continue to return to **Form 8: Health Center Agreements** list page. Following the steps described above, add as many organizations and corresponding agreements as referenced in [Part I](#). This form will accept a maximum of five document uploads for 10 organizations
5. After completing **Form 8**, click the Save and Continue button to save your work and proceed to the next form.

3.14 Form 9: Need for Assistance Worksheet

Form 9: Need for Assistance Worksheet documents objective measures of relative need for the proposed service area and target population. Refer to the Data Resource Guide at <http://www.hrsa.gov/grants/apply/assistance/NAP> for guidance regarding appropriate data sources and extrapolation methodologies. This form consists of the following sections:

[Section I - Core Barriers](#) (Figure 57, 1)

[Section II - Core Health Indicators](#) (Figure 57, 2)

[Section III - Other Health and Access Indicators](#) (Figure 57, 3)

IMPORTANT NOTE: Refer to Appendix A in the FY16 NAP Funding Opportunity Announcement for information on completing the Need for Assistance worksheet and how it is scored.

3.14.1 Completing Section I – Core Barriers

Form 9 - Section I requests information about the Core Barriers to health care access in the proposed service area and for the target population. You must report only three of the four core barriers listed. To complete this section, follow the steps below:

1. Click on the [Edit](#) link for each of the Core Barriers (Figure 57, 4).

Figure 57: Form 9, Section I - Core Barriers

Form 9 - Need for Assistance Worksheet

Due Date: 10/15/2016 (Due In: 10 Days) | Section Status: Not Complete

Resources 1

2 Section I - Core Barriers Section II - Core Health Indicators Section III - Other Health and Access Indicators

Scores

NFA Score	Converted Score
0.00	0

Note(s):
Provide information for three out of the four Core Barriers listed below.

Core Barrier	Is this Core Barrier Applicable	Status	Score	Options
Population to one FTE primary care physician		Not Started	0	3 Edit 4
Percent of Population Below 200 Percent of Poverty		Not Started	0	Edit
Percent of Population Uninsured		Not Started	0	Edit
Distance (miles) OR travel time (minutes) to nearest primary care provider accepting new Medicaid and uninsured patients		Not Started	0	Edit

Go to Previous Page Save Save and Continue

- The system navigates to the details page of the selected Core Barrier (Figure 58).
2. For those Core Barriers you will report on, respond 'Yes' to the question 'Is this Core Barrier Applicable?' (Figure 58, 1). For one of the Core Barriers, you must answer 'No' to the question 'Is this Core Barrier Applicable?' (Figure 58, 1). If you answer 'No' to 'Is this Core Barrier Applicable?' you will *not* be able to enter any data for that barrier.
3. Provide information in all the fields of the core barrier.

Figure 58: Section I - Core Barrier Details

Core Barrier: Population to one FTE primary care physician

Fields with * are required

- * Is this Core Barrier Applicable 1 ☐ Yes ☐ No
- * Data Response 1 (Enter a number up to 2 decimals) : 1 Ratio
- * Year to Which Data Apply 1 (yyy)
- * Data Source/Description 1

Approximately 1/4 page 1 (Max 500 Characters): 500 Characters left.
- * Methodology Utilized/Extrapolation Method 1

Approximately 1/4 page 1 (Max 500 Characters): 500 Characters left.
- * Identify Geographic Service Area or Target Population for Data 1

Approximately 1/8 page 1 (Max 100 Characters): 100 Characters left.

Cancel Save and Continue

- Click the Save and Continue button to return to the **Core Barriers – List** page ([Figure 59](#)).

IMPORTANT NOTE: The NFA score for each reported Core Barrier is listed under the individual Score column ([Figure 59](#), 2). You can also review the cumulative scores for all of the sections in Form 9 in the Scores section ([Figure 59](#), 1).

- Complete the remaining Core Barriers and click on the Save and Continue button to proceed to **Section II – Core Health Indicators** section, or click the Save button at the bottom of this section and select the **Section II – Core Health Indicators** tab below the **Resources** section ([Figure 59](#), 3).

Figure 59: Section I - Core Barriers Completed

✔ Section I - Core Barriers
✖ Section II - Core Health Indicators
✖ Section III - Other Health and Access Indicators

Scores 3

NFA Score	Converted Score
40.00	8 1

Note(s):
Provide information for three out of the four Core Barriers listed below.

Core Barrier	Is this Core Barrier Applicable	Status	Score	Options
Population to one FTE primary care physician	Yes	Complete	0	Edit
Percent of Population Below 200 Percent of Poverty	No	Complete	0	Edit
Percent of Population Uninsured	Yes	Complete	20 2	Edit
Distance (miles) OR travel time (minutes) to nearest primary care provider accepting new Medicaid and uninsured patients	Yes	Complete	20	Edit

Go to Previous Page Save Save and Continue

3.14.2 Completing Section II – Core Health Indicators

In **Form 9 - Section II**, report data for one indicator in each of the listed Core Health Indicator categories. To complete this section, follow the steps below for each of the Core Health Indicators:

1. Click on the [Edit](#) link for each of the Core Health Indicator categories ([Figure 60, 1](#)).

Figure 60: Form 9, Section II - Core Health Indicators

Section I - Core Barriers Section II - Core Health Indicators Section III - Other Health and Access Indicators

Scores

NFA Score	Converted Score
40.00	8

Note(s):

- Provide information for all six health indicator categories listed below. You are required to select one Core Health Indicator for each category and provide complete information for the selected indicator.
- If you choose to propose 'Other' health indicator in any of the categories, you must provide the description of the indicator and select appropriate data unit while providing Data Response

Category	Status	Score	Options
Diabetes	Not Started	0	Edit
Cardiovascular Disease	Not Started	0	Edit
Cancer	Not Started	0	Edit
Prenatal and Perinatal Health	Not Started	0	Edit
Child Health	Not Started	0	Edit
Behavioral Health	Not Started	0	Edit

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

2. Select a Core Health Indicator from the drop-down menu ([Figure 61, 1](#)). If you choose 'Other', then you are required to specify the name of your Core Health Indicator.

Figure 61: Select a Core Health Indicator

Category: Diabetes

Score: 0

Fields with * are required

* Category

[Return To List](#) [Save and Continue](#)

Age-adjusted diabetes prevalence

Age-adjusted diabetes prevalence

Adult obesity prevalence

Age-adjusted diabetes mortality rate (per 100,000)

Percentage of diabetic Medicare enrollees not receiving a hemoglobin A1c (HbA1c) test

Percent of adults (18 years and older) with no physical activity in the past month

Other

- The system refreshes with the National Benchmark ([Figure 62, 1](#)), Severe Benchmark ([Figure 62, 2](#)) values and the measure unit of the Data Response field ([Figure 62, 3](#)).

IMPORTANT NOTE: For the Core Barriers and Core Health Indicators that are measured in percentage (%), the Data Response must be within 0 – 100.

Figure 62: Core Health Indicator - Data Response

Category: Diabetes

Score: 0

Fields with * are required

Category	Age-adjusted diabetes prevalence
* National Benchmark	8.1% 1
* Severe Benchmark	9.2% 2
* DataResponse	4 3

Previous Return to List Save and Continue

3. Provide the **Data Response** value (Figure 62, 4) and click the Save and Continue button.
4. In the next screen, provide information in all the remaining fields of the core health indicator and click the Save and Return to List button (Figure 63, 1) to return to the **Core Health Indicator – List** page.

Figure 63: Section II - Core Health Indicator Details

Category: Diabetes

Score: 5

Fields with * are required

Category	Age-adjusted diabetes prevalence
National Benchmark	8.1%
Severe Benchmark	9.2%
DataResponse	14%
* Year to Which Data Apply ⓘ	(yyyy)
* Data Source/Description ⓘ	Approximately 1/4 page ⓘ (Max 500 Characters): 500 Characters left.
* Methodology Utilized/Extrapolation Method ⓘ	Approximately 1/4 page ⓘ (Max 500 Characters): 500 Characters left.
* Identify Geographic Service Area or Target Population for Data ⓘ	Approximately 1/8 page ⓘ (Max 100 Characters): 100 Characters left.

Previous Return to List 1 Save and Return to List

IMPORTANT NOTES: If you choose to select 'Other' as your Core Health Indicator, you must specify the indicator (Figure 64, 1) and complete the following subsequent fields:

- Select a comparison criterion (e.g., greater than) for the National Benchmark (Figure 65, 1) and provide its number value and measure unit (e.g., percent, ratio) (Figure 65, 2).

- Provide the data response value in the Data Response field and choose the corresponding measure unit in the dropdown box (Figure 65, 3). Ensure that the measure unit is in sync with the National Benchmark selection.
- Click Save and Continue to provide information in all the remaining fields of the core health indicator.

Figure 64: Specifying 'Other' Core Health Indicator

Category: Diabetes

Score: 0

Fields with * are required

* Core Health Indicator Other 1

* If 'Other', please specify 2

Return To List Save and Continue

Figure 65: 'Other' Core Health Indicator Details

Category: Diabetes

Score: 0

Fields with * are required

Core Health Indicator Other Core Health Indicator 1

* National Benchmark Select One 2 Select One 2

If 'Other', please specify:

* Severe Benchmark N/A

* Data Response Select One 3

If 'Other', please specify:

Previous Return to List Save and Continue

5. Complete the remaining Core Health Indicators and proceed to **Section III – Other Health and Access Indicators** section (Figure 66, 1).

Figure 66: Section II - Core Health Indicator Completed

Section I - Core Barriers ✓ Section II - Core Health Indicators ✓ Section III - Other Health and Access Indicators 1

Scores	
NFA Score	Converted Score
70.00	14

Note(s):

- Provide information for all six health indicator categories listed below. You are required to select one Core Health Indicator for each category and provide complete information for the selected indicator.
- If you choose to propose 'Other' health indicator in any of the categories, you must provide the description of the indicator and select appropriate data unit while providing Data Response

Category	Status	Score	Options
Diabetes	Complete	5	Edit
Cardiovascular Disease	Complete	5	Edit
Cancer	Complete	5	Edit
Prenatal and Perinatal Health	Complete	5	Edit
Child Health	Complete	5	Edit
Behavioral Health	Complete	5	Edit

Go to Previous Page Save Save and Continue

3.14.3 Completing Section III – Other Health and Access Indicators

Use **Form 9 - Section II** to provide information about two additional health and access indicators. To complete this section, follow the steps below:

1. Click on the [Edit](#) link for each of the Other Health and Access Indicators ([Figure 67](#), 1).

Figure 67: Form 9, Section III - Other Health and Access Indicators

Section I - Core Barriers ✓ Section II - Core Health Indicators ✓ Section III - Other Health and Access Indicators 1

Scores	
NFA Score	Converted Score
70.00	14

Note(s):

Provide information for two out of thirteen of the Other Health and Access Indicators listed below.

Other Health and Access Indicator	Status	Score	Options
Indicator #1	Not Started	0	Edit
Indicator #2	Not Started	0	Edit

Go to Previous Page Save Save and Continue

2. Select an Other Health and Access Indicator from the drop-down menu ([Figure 68](#)) and click the Save and Continue button.

Figure 68: Select an Other Health and Access Indicator

- The system refreshes with the National Benchmark (**Figure 69, 1**) and the measure unit of the Data Response field (**Figure 69, 3**). The Severe Benchmark is not applicable (**Figure 69, 2**).

Figure 69: Other Health and Access Indicator - Data Response

3. Provide the **Data Response** value (**Figure 69, 4**) and click the Save and Continue button.
4. In the next screen, provide information in all the remaining fields of the indicator and click the Save and Return to List button to return to the **Other Health and Access Indicators – List** page.
5. Repeat steps 1-4 for another indicator.

Figure 70: Form 9 Completed

Form 9 - Need for Assistance Worksheet

Success:
Information entered on Section III - Other Health and Access Indicators was saved successfully. This form is now Complete.

SECTION: TRICITIES COMMUNITY HEALTH Due Date: 10/15/2018 (Due In: 10 Days) | Section Status: Complete

Resources

Section I - Core Barriers Section II - Core Health Indicators **Section III - Other Health and Access Indicators**

Scores

NFA Score	Converted Score
80.00	16

Note(s):
Provide information for two out of thirteen of the Other Health and Access Indicators listed below.

Other Health and Access Indicator	Status	Score	Options
Indicator #1	Complete	5	Edit
Indicator #2	Complete	5	Edit

Go to Previous Page Save Save and Continue

6. **Form 9: Need for Assistance Worksheet** will be complete when the status of all 3 sections are complete ([Figure 70](#)). After completing all the form sections, click the Save and Continue button to save your work and proceed to the next form.

3.15 Form 10: Emergency Preparedness Report

Form 10: Emergency Preparedness Report assesses your organization's overall emergency readiness. To complete this form, follow the steps below:

1. Complete all sections of this form by selecting a 'Yes' or 'No' response for each question ([Figure 71](#)).
2. After providing complete information on **Form 10**, click the Save and Continue to save the information and proceed to the next form.

Form 10 - Emergency Preparedness Report

Due Date: 07/14/2015 (Due in 37 Days) | Section Status: Not Started

Resources

Fields with * are required

Section I : Emergency Preparedness and Management Plan

* 1) Has your organization conducted a thorough Hazards Vulnerability Assessment?
If Yes, date completed: (mm/dd/yyyy)

☐ Yes ☐ No

* 2) Does your organization have an approved EPM plan?
If Yes, date most recent EPM plan was approved by your Board: (mm/dd/yyyy)
If No, skip to Readiness section below.

☐ Yes ☐ No

3) Does the EPM plan specifically address the four disaster phases?
This question is mandatory if you answered Yes to Question 2.

3a) Mitigation ☐ Yes ☐ No

3b) Preparedness ☐ Yes ☐ No

3c) Response ☐ Yes ☐ No

3d) Recovery ☐ Yes ☐ No

4) Is your EPM plan integrated into your local/regional emergency plan?
This question is mandatory if you answered Yes to Question 2.

☐ Yes ☐ No

5) If no, has your organization attempted to participate with local/regional emergency planners?
This question is mandatory if you answered Yes to Question 2 and No to Question 4.

☐ Yes ☐ No

6) Does the EPM plan address your capacity to render mass immunization/prophylaxis?
This question is mandatory if you answered Yes to Question 2.

☐ Yes ☐ No

Section II : Readiness

* 1) Does your organization include alternatives for providing primary care to your current patient population if you are unable to do so during emergency?

☐ Yes ☐ No

* 2) Does your organization conduct annual planned drills?

☐ Yes ☐ No

* 3) Does your organization's staff receive periodic training on disaster preparedness?

☐ Yes ☐ No

* 4) Will your organization be required to deploy staff to Non-Health Center sites/locations according to the emergency preparedness plan for local community?

☐ Yes ☐ No

* 5) Does your organization have arrangements with Federal, State and/or local agencies for the reporting of data?

☐ Yes ☐ No

* 6) Does your organization have a back-up communication system?

6a) Internal ☐ Yes ☐ No

6b) External ☐ Yes ☐ No

* 7) Does your organization coordinate with other systems of care to provide an integrated emergency response?

☐ Yes ☐ No

* 8) Has your organization been designated to serve as a point of distribution (POD) for providing antibiotics, vaccines and medical supplies?

☐ Yes ☐ No

* 9) Has your organization implemented measures to prevent financial/revenue and facilities loss due to an emergency?
(e.g. Insurance coverage for short-term closure)

☐ Yes ☐ No

* 10) Does your organization have an off-site back up of your information technology system?

☐ Yes ☐ No

* 11) Does your organization have a designated EPM coordinator?

☐ Yes ☐ No

[Go to Previous Page](#) [Save](#) [Save and Continue](#)

Use **Form 12: Organization Contacts** to provide contact information for the proposed project.

New applicants will provide the requested contact information. For existing award recipients submitting a satellite application, the system will pre-populate the contact information from the latest awarded Health Center Program application.

To complete this form, follow the steps below:

1. Enter contact information for the Chief Executive Officer, Contact Person, Clinical Director, and Dental Director (optional) by clicking on the Add button. (Figure 72, 1, 2, 3, 4)

Figure 72: Form 12 – Organization Contacts

Form 12 - Organization Contacts

Due Date: 8/7/16 2016 (Due In: 10 Days) | Section Status: Not Started

Resources

Fields with * are required

Contact Information	Name	Highest Degree	Email	Phone Number	Option
* Chief Executive Officer					1 Add Chief Executive Officer
* Contact Person					2 Add Contact Person
* Clinical Director					3 Add Clinical Director
Dental Director					4 Add Dental Director

Go to Previous Page Save Save and Continue

2. Click on the **Add/Update** link to add or update the information for each type of contact.
 - The system directs you to the data entry page for the corresponding contact.
3. To delete the contact information already provided, click on the **Delete** link under the options column.

IMPORTANT NOTE: The **Update** and the **Delete** links will be only displayed once you have added the contact information.

4. Enter the required information on this page.

Figure 73: Chief Executive Officer – Add page

Chief Executive Officer - Add

Due Date: 12/15/2016 (Due In: 10 Days)

Resources

Fields with * are required

Add New Contact Information

Position Title: Chief Executive Officer

Prefix: Select Option

* First Name: [Text Field]

* Last Name: [Text Field]

Middle Initial: [Text Field]

Suffix: Select Option
If "Other", please specify: [Text Field] (maximum 100 characters)

Highest Degree: Select Option
If "Other", please specify: [Text Field] (maximum 100 characters)

* Email Address: [Text Field]

* Phone Number: [Text Field] - [Text Field] Ext. [Text Field]

Cancel Save Save and Continue

5. Click Save to save the information and remain on the same page or click Save and Continue to save the information and proceed to the **Form 12: Organizations Contact** page to add information for the next contact.
6. After providing complete information on **Form 12**, click the Save and Continue button to save the information and proceed to the next form.

3.17 Clinical Performance Measures

The **Clinical Performance Measures** form collects the goals and performance measures for the NAP project.

IMPORTANT NOTE: Refer to the FY16 NAP Funding Opportunity Announcement for more information on completing the **Clinical Performance Measures** form.

The **Clinical Performance Measures** form displays the following sections:

- [Standard Measures](#)
- [Other Measures](#)

Standard Measures are pre-defined measures; applicants are required to provide requested information for all these measures. **Other Measures** are optional additional measures that applicants may wish to add to their application.

3.17.1 Completing the Standard Clinical Performance Measures

To complete this form:

1. Click on the [Update](#) link to start working on a performance measure ([Figure 74, 1](#)).

Figure 74: Clinical Performance Measures page

Clinical Performance Measures

Due Date: 10/15/2016 (Due In: 88 Days) | Section Status: Not Started

Resources

Add Other Performance Measure

Collapse Group | Detailed View

Focus Area	Performance Measure	Baseline Data	Baseline Year	Projected Data	Status	Options
			All		All	
Standard Measures						
Diabetes	Proportion of adult patients with a diagnosis of Type I or Type II diabetes whose hemoglobin A1c (HbA1c) was greater than 9% at the time of the last reading in the measurement year.				Not Complete	Update
Cardiovascular Disease	Proportion of adult patients with diagnosed hypertension whose blood pressure was less than 140/90 (adequate control) at the time of the last reading.				Not Complete	Update
Cancer	Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.				Not Complete	Update
Prenatal Health	Proportion of prenatal care patients who entered treatment during their first trimester.				Not Complete	Update
Perinatal Health	Proportion of patients born to health center patients whose birth weight was below normal (less than 2,500 grams).				Not Complete	Update
Child Health	Percentage of children with their 3rd birthday during the measurement year who are fully immunized before their 3rd birthday.				Not Complete	Update
Oral Health	Percentage of children age 6-9 years at "elevated" risk who received a sealant on a permanent first molar tooth within the measurement year.				Not Complete	Update
Weight Assessment and Counseling for Children and Adolescents	Percentage of patients aged 2 until 17 who had evidence of BMI percentile documentation AND who had documentation of counseling for nutrition AND who had documentation of counseling for physical activity during the measurement year.				Not Complete	Update
Adult Weight Screening and Follow-Up	Percentage of patients aged 18 and older with a documented BMI during the most recent visit or within the 6 months prior to that visit AND when the BMI is outside of normal parameters a follow-up plan is documented.				Not Complete	Update
Tobacco Use Screening and Cessation	Percentage of patients age 18 years and older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.				Not Complete	Update
Asthma – Pharmacological Therapy	Percentage of patients aged 5 through 40 with a diagnosis of mild, moderate, or severe persistent asthma who received or were prescribed accepted pharmacologic therapy.				Not Complete	Update
Coronary Artery Disease (CAD): Lipid Therapy	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) who were prescribed a lipid-lowering therapy.				Not Complete	Update
Ischemic Vascular Disease (IVD): Aspirin Therapy	Percentage of patients aged 18 years and older who were discharged alive for acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) in the prior year OR who had a diagnosis of ischemic vascular disease (IVD) during the measurement year who had documentation of use of aspirin or another antithrombotic.				Not Complete	Update
Colorectal Cancer Screening	Percentage of patients age 50 to 75 years who had appropriate screening for colorectal cancer.				Not Complete	Update
HIV Linkage to Care	Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis.				Not Complete	Update
Depression Screening and Follow Up	Percentage of patients aged 12 and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.				Not Complete	Update

Go to Previous Page
Save
Save and Continue

IMPORTANT NOTE: The **Clinical Performance Measures** form will be 'Complete' when the status of all Standard measures and Other measures are 'Complete'. All standard measures are required and must be completed.

- The system navigates to the **Clinical Performance Measure – Update** page (Figure 75).

Figure 75: Clinical Performance Measure - Update page

Clinical Performance Measures - Update

Due Date: 12/31/2016 (Due In: 10 Days) | Section Status: Not Complete

Resources

Fields with * are required

Update Clinical Performance Measure Information

Focus Area: Diabetes

Is this performance measure applicable to your organization? Yes

Performance Measure: Proportion of adult patients with a diagnosis of Type I or Type II diabetes whose hemoglobin A1c (HbA1c) was greater than 9% at the time of the last reading in the measurement year.

Approximately 1/4 page (Max 500 Characters): 500 Characters left

Target Goal Description (Sample Goals) 1

Numerator Description (Examples) 2

Denominator Description (Examples)

Baseline Data

Baseline Year: (yyyy)

Measure Type: Percentage

Numerator:

Denominator:

Calculate Baseline 4

Projected Data (by End of Project Period) (Sample Calculation) 3

Projected Data:

Measure Type: Percentage

☐ EHR

☐ Chart Audit

☐ Other If 'Other', please specify: (maximum 100 characters)

Data Sources & Methodology

Approximately 1/4 page (Max 500 Characters): 500 Characters left

Add New Key Factor and Major Planned Action 5

List of Key Factors and Major Planned Actions (Minimum 2) (Maximum 3)

Key Factor Type	Description	Major Planned Action	Options
No key factors and major planned actions added			

Comments (Required if performance measure is not applicable)

Approximately 3/4 page (Max 1500 Characters): 1500 Characters left

Cancel 7 **Save** 6 **Save and Continue to List** 8 **Save and Update Next** 8

2. Provide a **Target Goal Description**, for each performance measure (Figure 75, 1). For all standard measures, the **Numerator** and **Denominator** descriptions are pre-populated (Figure 75, 2).
3. For Baseline Data, enter the year of the data provided and the numerator and denominator values based on the descriptions given. Use the Calculate Baseline button to calculate the baseline percentage (Figure 75, 4).
4. Enter the goal by the end of the two-year project period under **Projected Data (by End of Project Period)** as a percentage (Figure 75, 3).

5. Select 'EHR', 'Chart Audit', or 'Other' as the **Data Source**. If 'Other' is selected, specify the data source. Describe the **Methodology** used to collect and analyze data.
6. Click on the Add New Key Factor and Major Planned Action button to add Key factors (Figure 75, 5).
 - The system navigates to the **Key Factor and Major Planned Action – Add** page (Figure 76).
7. Provide information for at least one restricting and one contributing Key Factor type.

Figure 76: Key Factors and Major Planned Action - Add page

8. Click the Save and Continue button (Figure 76, 1) to save the information on this page and proceed to the **Clinical Performance Measures – Update** page, or click the Save and Add New button (Figure 76, 2) to save the information on this page and proceed to add a new key factor.
9. Provide comments in the Comment field if needed (Figure 75, 6).
10. Click on the Save button to save the information on this page (Figure 75, 7). To go to the **Clinical Performance Measure – List** page, click on the Save and Continue to List button (Figure 75, 8) or click on the Save and Update Next button to update the next performance measure in the list (Figure 75, 9).

3.17.2 Adding Other Performance Measures

To add an 'Other' performance measure to your application, follow the steps below:

1. Click the Add Other Performance Measure button at the top of the **Clinical Performance Measure – List** page.
 - The **Add Clinical Performance Measure** page opens.

Figure 77: Add Clinical Performance Measure

The screenshot shows the 'Add Clinical Performance Measure Information' form. It includes a 'Focus Area' dropdown menu (labeled 1) and a 'Load Performance Measure Category' button (labeled 2). Below the dropdown is a list of checkboxes for 'All', 'Mental Health', 'Substance Abuse Conditions', and 'Other'. There are also two text input fields for 'If 'Other', please specify:' with a '(maximum 100 characters)' limit.

2. Select a focus area from the drop-down menu ([Figure 77, 1](#)).
3. If the focus area is Oral Health or Behavioral Health, click on the Load Performance Measure Category button to load the performance measure categories ([Figure 77, 2](#)). Otherwise, the Load Performance Measure Category button is not applicable.
4. Select one or more performance measure categories, as applicable.
5. Provide all the required information.
6. Click on the Add New Key Factor and Major Planned Action button to add Key Factors. Provide information for at least one restricting and one contributing Key Factor type.
7. Click on the Save button to save the information on this page. To go to the **Clinical Performance Measure – List** page, click on the Save and Continue button. The newly added measure will be listed under **Other Measures** at the bottom of the page.
8. Newly added 'Other' measures can be updated or deleted by using the [Update](#) and [Delete](#) links provided as options.
9. After completing all of the Clinical Measures, click the Save and Continue button to save the information and proceed to the next form.

IMPORTANT NOTE: If applying for funds to target one or more special populations (i.e., MHC, HCH, PHPC) in addition to the general community, applicants must include at least one additional Clinical Performance Measure that addresses the unique health care needs of the special population(s).

3.18 Financial Performance Measures

The **Financial Performance Measures** form collects the goals and performance measures for the NAP project. It displays the following sections:

- [Standard Measures](#)
- [Other Measures](#)

Standard Measures are pre-defined measures; applicants are required to provide requested information for all these measures. **Other Measures** are optional additional measures that applicants may wish to add to their application.

3.18.1 Completing the Standard Financial Performance Measures

To complete this form:

1. Click on the **Update** link to start working on a performance measure (Figure 78, 1).

Figure 78: Financial Performance Measures – List page

The screenshot shows the 'Financial Performance Measures - List' page. At the top, there's a header with 'Due Date: 07/01/2018 (Due In: 30 Days) | Section Status: Not Started'. Below this is a 'Resources' section with a link to 'Add Other Performance Measure'. The main table has columns: Focus Area, Performance Measure, Baseline Data, Baseline Year, Projected Data, Status, and Options. Under 'Standard Measures', there are three rows: 'Total cost per patient', 'Medical cost per medical visit', and 'Health Center Program Grant Cost Per Patient'. All three are marked as 'Not Complete'. The 'Update' link in the 'Options' column for the first row is highlighted with a red box and a red circle with the number '1'.

Focus Area	Performance Measure	Baseline Data	Baseline Year	Projected Data	Status	Options
			All		All	
Standard Measures						
Costs	Total cost per patient				Not Complete	Update
Costs	Medical cost per medical visit				Not Complete	Update
Grant Costs	Health Center Program Grant Cost Per Patient				Not Complete	Update

IMPORTANT NOTE: The **Financial Performance Measures** form will be 'Complete' when the status of all Standard measures and Other measures are 'Complete'. All standard measures are required and must be completed.

- The system navigates to the **Financial Performance Measure – Update** page (Figure 79).

Figure 79: Financial Performance Measure - Update Page

Financial Performance Measures - Update

Due Date: 07/15/2015 (Due In: 0 Days) | Section Status: Not Complete

Resources

Fields with * are required

Update Financial Performance Measure Information

Focus Area	Costs
Is this performance measure applicable to your organization?	Yes
Performance Measure	Total cost per patient.
* Target Goal Description (Sample Goals ?)	Approximately 1/4 page (Max 500 Characters): 500 Characters left.
* Numerator Description (Examples ?)	Total accrued cost before donations and after allocation of overhead.
Denominator Description (Examples ?)	Total unduplicated patients for the period from January 1 to December 31 of the calendar measurement year.
* Baseline Data	Baseline Year: <input type="text"/> (yyyy) Measure Type: Ratio Numerator: <input type="text"/> Denominator: <input type="text"/> <input type="button" value="Calculate Baseline"/>
* Projected Data (by End of Project Period) (Sample Calculation ?)	Projected Data: <input type="text"/> Measure Type: Ratio Approximately 1/4 page (Max 500 Characters): 500 Characters left.
* Data Sources & Methodology	Approximately 1/4 page (Max 500 Characters): 500 Characters left.

[Add New Key Factor and Major Planned Action](#)

* List of Key Factors and Major Planned Actions (Minimum 2) (Maximum 3)

Key Factor Type	Description	Major Planned Action	Options
No key factors and major planned actions added			

Comments (Required if performance measure is not applicable)

Approximately 3/4 page (Max 1500 Characters): 1500 Characters left.

2. Provide a **Target Goal Description**, for each performance measure (Figure 79, 1). For all standard measures, the **Numerator** and **Denominator** descriptions are pre-populated.
3. For Baseline Data, enter the year of the data provided and the numerator and denominator values based on the descriptions given. Use the Calculate Baseline button to calculate the baseline data. (Figure 79, 2)
4. Enter the goal by the end of the two-year project period under **Projected Data (by End of Project Period)**.
5. Describe the **Data Sources & Methodology** used to collect and analyze data.

6. Click on the Add New Key Factor and Major Planned Action button to add Key Factors. Provide information for at least one restricting and one contributing Key Factor type.
7. Click the Save and Return to Performance Measure button to save the information on the **Key Factor and Major Planned Action - Add** page and proceed to the **Financial Performance Measures – Update** page, or click the Save and Add Another Key Factor button to save the key factor information you provided and proceed to add a new key factor.
8. Provide comments in the Comment field if needed.
9. Click on the Save button to save the information on this page. To go to the **Financial Performance Measures** page, click on the Save and Continue to List button or click on the Save and Update Next button to update the next performance measure in the list.

3.18.2 Adding Other Performance Measures

To add an 'Other' financial performance measure to your application, follow the steps below:

1. Click the Add Other Performance Measure button on the Financial Performance Measures list page.
 - The **Financial Performance Measures – Add** page opens.
2. Select a focus area from the drop-down menu.
3. Provide all the required information.
4. To add the key factors, click on the Add New Key Factor and Major Planned Action button. Provide information for at least one restricting and one contributing Key Factor type.
5. Click on the Save button to save the information on this page. To go to the performance measure list page, click on the Save and Continue button. The newly added measure will be listed under the **Other Measures** at the bottom of the **Financial Performance Measures** page.
6. Newly added 'Other' measures can be updated or deleted by using the **Update** and **Delete** links provided as options.
7. After completing all of the Financial Measures, click the Save and Continue button to save the information and proceed to the next form.

3.19 Equipment List

The **Equipment List** form provides a line-item list of proposed equipment to be purchased with grant funds.

IMPORTANT NOTE: If you requested One-Time Funding for Year 1 in [Form 1B: Funding Request Summary](#) and indicated that you will be using these funds for 'Equipment only' or for 'Minor Alteration and Renovation with Equipment', you will be required to complete the **Equipment List** form. Otherwise, this form is not applicable ([Figure 80](#)). If the form is not applicable to you, click the Continue button to proceed to the next form.

Figure 80: Equipment List Page – Not Applicable

The screenshot shows the 'Equipment List' page for 'OHTHOMAS ALBANY AREA PRIMARY HEALTH CARE, INC.'. The page header indicates the 'Due Date: 05/01/2018 (Due In: 54 Days)' and 'Section Status: Complete'. A yellow alert box states: 'Alert: This form is not applicable to you as in Form 1B of this application, one of the following is true: You have not requested one-time funding, or You have requested one-time funding but not indicated how you plan to use these funds, or You have requested one-time funding for minor alteration/renovation without equipment use'. At the bottom, there are buttons for 'Go to Previous Page' and 'Continue'.

To complete this form when it is applicable, follow the steps below:

1. Click the Add button to add equipment ([Figure 81](#)).

Figure 81: Equipment List Page

The screenshot shows the 'Equipment List' page for 'OHTHOMAS ALBANY AREA PRIMARY HEALTH CARE, INC.'. The page header indicates the 'Due Date: 05/01/2018 (Due In: 54 Days)' and 'Section Status: Not Started'. A red box highlights the 'Add' button. Below the button is a table titled 'List of Equipment' with columns: Type, Description, Unit Price, Quantity, Total Price, and Options. The table currently shows 'No equipment added.' At the bottom, there are buttons for 'Go to Previous Page', 'Save', and 'Save and Continue'.

2. The system navigates to the **Equipment Information - Add Page** ([Figure 82](#)).

Figure 82: Equipment Information - Add Page

The screenshot shows the 'Add Equipment Information' page. It includes a header 'Fields with * are required'. The form has four required fields: 'Type' (a dropdown menu with 'Clinical' and 'Non-Clinical' options), 'Description' (a text field with a '(Maximum 50 Characters)' hint), 'Unit Price (\$)' (a text field), and 'Quantity' (a text field). At the bottom, there are buttons for 'Cancel' and 'Save and Continue'.

3. Select an equipment Type and enter the Description, Unit Price (\$), and Quantity.
4. Click the Save and Continue button at the bottom of the screen. You will be returned to the **Equipment List** page ([Figure 83](#)).

Figure 83: Equipment List Page with Equipment Added

The screenshot shows a web application interface for managing equipment. At the top left is an 'Add' button. Below it is a section titled 'List of Equipment' containing a table. The table has columns for 'Type', 'Description', 'Unit Price', 'Quantity', 'Total Price', and 'Options'. There are two rows of equipment: 'Clinical' with 'Testing Equipment' at \$20,000.00 each, and 'Non-Clinical' with 'Metal Detector' at \$1,000.00 each. A 'Total' row shows a quantity of 3 and a total price of \$40,000.00. To the right of the table, there is an 'Action' menu with 'Update' and 'Delete' options. Red callout boxes with numbers 1 and 2 point to the 'Update' and 'Delete' links respectively. At the bottom left is a 'Go to Previous Page' button, and at the bottom right are 'Save' and 'Save and Continue' buttons.

Type	Description	Unit Price	Quantity	Total Price	Options
Clinical	Testing Equipment	\$20,000.00	1	\$20,000.00	Update
Non-Clinical	Metal Detector	\$1,000.00	2	\$2,000.00	Update
Total			3	\$40,000.00	Delete

5. To edit an equipment list item, click on the **Update** link under the Options menu (Figure 83, 1). To delete an equipment item, click on the **Delete** link under the Options menu (Figure 83, 2).

IMPORTANT NOTE: If you are requesting One-Time Funding in [Form 1B: Funding Request Summary](#) for 'Equipment only', the total price of equipment requested in this form must be equal to the One-Time Funds request. Otherwise, the total price can be less than the one-time funds requested.

6. When you have finished entering the equipment, click the **Save and Continue** button at the bottom of the screen to save your work and proceed to the next form.

3.20 Summary Page

This form displays read-only information provided in the following program specific forms of the NAP application: [Form 1A](#), [Form 1B](#), [Form 2](#), [Form 5B](#) and [Form 9](#). You are required to acknowledge and certify that the information displayed in this form is correct.

1. Review the data displayed on the **Summary** page (Figure 84) for accuracy. If any information is incorrect, edit the forms by clicking on the form name in the left navigation panel. Be advised that the information in the forms should be consistently identified throughout the entire application.
2. When all information is complete and accurate, click the check box to certify the form and then click the Save and Continue button.

IMPORTANT NOTE: If you update the information in any of the related forms after completing the **Summary Page**, you will be required to revisit the **Summary Page** to review and acknowledge the updated information.

Figure 84: Summary Page

Summary Page

Note(s):
 The information below is pre-populated based on data that you provided in the forms of this NAP application. If any information is incorrect, please edit the forms by clicking on the form name in the Menu on the left of the screen. Be advised that the information in the forms should be consistently identified throughout the entire application.

Warning:
 One or more details displayed below may have been updated in one of the forms (Form 1A, Form 1B, Form 2, Form 5B, or Form 9) of this NAP Application. Please review the information on this form and click 'Save' button displayed at the bottom of this page.

UNDESIGNED: THE CENTER COMMUNITY HEALTH

Due Date: 12/31/2018 (Due In: 88 Days) | Section Status: Not Started

Resources

Summary Information

1. I am applying as a new start applicant.

Suggested Resource(s): [Form1A](#)

☒ Yes ☐ No

Note:

- "Yes" indicates that you are a new organization applying for section 330 operational funds.
- "No" indicates that you are a current section 330 grantee. Therefore, you are applying as a Satellite applicant.

2. I am proposing the following sites, which will be open within 120 days of award:

These are the NAP proposed sites and service area. If changes are required, revisit [Form 5B](#)

Site Name	Physical Street Address for Site	Service Site Type	Location Type	Service Area Zip Codes
12345 Main Street	12345 Kennedy Rd, West Richmond, VA 23090-1234	Administrative/Service Delivery Site	Permanent	23140

3. Total number of unduplicated patients projected to be served in calendar year 2018 (by December 31, 2018):

This is the NAP patient projection. If you are a satellite applicant, this figure will be added to your Patient Target. If changes are required, revisit [Form 1A](#)

0

4. I am requesting for the following types of Health Center funding:

This is the NAP Federal funding request. If changes are required, revisit [Form 1A](#) , [Form 1B](#)

Type of Health Center	Program	Operational funds for Year 1 (a)	Operational funds for Year 2 (b)	Funding population percentage for Year 2 (c)	Number of Patients at 12/31/2018 (d)	Federal Dollars Per Patient (e=b/d)
Community Health Centers	CHC-330(e)	-	\$0.00	0%	-	\$0.00
Health Care for the Homeless	HCH-330(h)	\$0.00	\$0.00	0%	-	\$0.00
Migrant Health Centers	MHC-330(g)	\$0.00	\$0.00	0%	-	\$0.00
Public Housing Primary Care	PHPC-330(i)	\$0.00	\$0.00	0%	-	\$0.00
Total		\$0.00	\$0.00	0%	0	\$0.00

5. I am requesting the following amount for one-time funding:

This is the NAP one-time Federal funding request. If changes are required, revisit [Form 1B](#)

One-time funding requested for Year 1: \$0
☐ Equipment only
☐ Minor alteration/renovation with equipment
☐ Minor alteration/renovation without equipment
☐ N/A

6. Total number of full time equivalent (FTE) staff at full capacity:

This is the proposed FTE staff for the NAP project. If changes are required, revisit [Form 2 \(Year 2\)](#)

0

7. Total Score from Form 9, Need For Assistance worksheet:

The converted score represents up to 20 points of the 30 available points in the Need section. If changes are required, revisit [Form 9](#)

NFA Score: 0
 Converted Score: 0

Certification

☐ By checking this box, I certify that information provided in this application is complete and accurate, including the Need for Assistance (NFA) data sources and calculations. I certify that, if funded, all sites included on Form 5B will be open and operational within 120 days of Notice of Award and I acknowledge that the health center will be held accountable for reaching the patient projections on Form 1A in calendar year 2018 (by December 31, 2018).

[Go to Previous Page](#)
[Save](#)
[Save and Continue](#)

4. Reviewing and Submitting the FY 2017 NAP Application to HRSA

To review your application, follow the steps below:

1. Navigate to the standard section of the application using the [Grant Application](#) link in the navigation links displayed at the top of the **Program Specific** forms.
2. On the **Application - Status Overview** page, click the [Review](#) link in the Review and Submit section of the left menu ([Figure 85, 1](#)).

Figure 85: Review Link

Application - Status Overview

Due Date: 8/15/2016 11:59:59 PM (Due in: 81 days) | Application Status: Complete

Announcement Number: HRSA-15-214 | Announcement Name: Affordable Care Act New Access Point Grants | Created by: John Daniels on 06/09/2016 2:31:00 PM
 Application Type: Competing Continuation | Grant Number: HRSA-15-214-000007 | Last Updated By: John Daniels on 06/09/2016 2:31:00 PM
 Application Package: SF424 | Application FY: 2016 | Program Type: Non-Construction

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | Application User Guide

Users with permissions on this application (1)

Section	Status	Options
Basic Information		
SF-424	Complete	
Part 1	Complete	Update
Part 2	Complete	Update
Project/Performance Site Location(s)	Complete	Update
Project Narrative	Complete	Update
Budget Information		
Section A-C	Complete	Update
Section D-F	Complete	Update
Budget Narrative	Complete	Update
Other Information		
Assurances	Complete	Update
Disclosure of Lobbying Activities	Complete	Update
Appendices	Complete	Update
Program Specific Information		
Program Specific Information	Complete	Update

➤ The system navigates to the **Review** page.

3. Verify the information displayed on the **Review** page.
4. If you are ready to submit the application to HRSA, click the Proceed to Submit button at the bottom of the **Review** page ([Figure 86, 1](#)).

Figure 86: Review Page – Proceed to Submit

Review

YIMB2: INDIAN COUNTY OP Due Date: 8/30/2016 11:59:59 PM (Due in: 88 days) | Application Status: In Progress

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance

Print Application Table of Contents

Page size: 50 20 Items in 1 page(s)

View	Section	Type	Options
View: Paper Attachments Scanned by HRSA			
Paper Attachments Scanned by HRSA	Scanned Paper Pages	DOCUMENT	Not Available
Paper Attachments Scanned by HRSA	Paper Application	DOCUMENT	Not Available
View: General Information			
General Information	Application for Federal Assistance (SF-424)	HTML	View
General Information	Application for Federal Assistance (SF-424) (Events.gov PDF)	DOCUMENT	Not Available

Page size: 50 20 Items in 1 page(s)

Proceed to Submit

- The system navigates to the **Submit** page.
5. Click the Submit to HRSA button at the bottom of the **Submit** page.
- The system navigates to a confirmation page.

IMPORTANT NOTES:

- To submit an application, you must have the 'Submit' privilege. This privilege must be given by the Project Director (PD) to the Authorizing Official (AO).
- If you are not the AO, a Submit to AO button will be displayed at the bottom of the Submit page. Click the button to notify the AO that their action is required to submit the application to HRSA ([Figure 87](#)).
- Applicants are strongly encouraged to notify the AO directly and ensure that they leave adequate time for the AO to complete the submission process prior to the deadline.

Figure 87: Submit to AO

ALL TASKS
Application - Submit

Grant Application

Overview
[Status](#)
Basic Information
[SF-424](#)
[Project/Performance Site Location\(s\)](#)
[Project Narrative](#)
Budget Information
[Section A-C](#)
[Section D-F](#)
[Budget Narrative](#)
Other Information
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[Disclosure of Lobbying Activities](#)
[Appendices](#)
Program Specific Information
[Program Specific Information](#)
Review and Submit
[Review](#)
[**Submit**](#)
Other Functions

Navigation
[Return to Applications List](#)

Due Date: 10/15/2014 11:58:00 PM (Due in: 4 days) |
Application Status: Complete

Announcement Number: HHS-15-014	Announcement Name: Affordable Care Act New Access Point Grants	Created by: John Delaney on 10/15/2014 3:31:00 PM
Application Type: Competing Continuation	Grant Number: 15AC00007	Last Updated By: John Delaney on 10/15/2014 3:31:00 PM
Application Package: SF424	Application FY: 2015	Program Type: Non-Construction

Resources [↗](#)

View

[Application](#) : [Action History](#) : [Funding Opportunity Announcement](#) : [FOA Guidance](#) : [Application User Guide](#)

Users with permissions on this application (1)

List of forms that are part of the application package		
Section	Status	Options
Basic Information		
SF-424	✓ Complete	
Part 1	✓ Complete	Update
Part 2	✓ Complete	Update
Project/Performance Site Location(s)	✓ Complete	Update
Project Narrative	✓ Complete	Update
Budget Information		
Section A-C	✓ Complete	Update
Section D-F	✓ Complete	Update
Budget Narrative	✓ Complete	Update
Other Information		
Assurances	✓ Complete	Update
Disclosure of Lobbying Activities	✓ Complete	Update
Appendices	✓ Complete	Update
Program Specific Information		
Program Specific Information	✓ Complete	Update

[Go to Previous Page](#)
[Submit to AO](#)

6. Answer the questions displayed under the Certifications and Acceptance section of the confirmation page and click the Submit Application button to submit the application to HRSA.
7. If you experience any problems with submitting the application in EHB, contact the **BPHC Helpline** at 1-877-974-2742 ext. 3 (Monday – Friday, 8:30 AM - 5:30 PM ET) or send an email through the **Web Request Form** (<http://www.hrsa.gov/about/contact/bphc.aspx>).